

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6484

CERTIFICATE OF DEATH

Reg. Dist. No.

06460

| | | | | | | | |
|---|--|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN 1b 9mths24dys | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS 33 2242 Sidney Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Margaret Middle Anna Last Ambrose | | | | 4. DATE OF DEATH Month June Day 2 Year 19 58 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 30, 1894 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10a. USUAL OCCUPATION | | 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that I attended the deceased from Dec. 31, 19 57 to June 2, 19 58 , that I last saw the deceased alive on June 2, 19 58 , and that death occurred at 1:15 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Stella Wachslar | | | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL | | DATE SIGNED 6-2-58 | |
| PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. | | | | Catonsville 28, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIED | | 22b. DATE THEREOF 19 JUNE 58 | | 22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 22d. LOCATION (City, town, or county) (State) OLD FREDERICK RD MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Bachman | | | | ADDRESS 637 Washington | | 24a. REC'D BY REGISTRAR DATE JUN 5 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. Beach | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX
RACE
OCCUPATION
EDUCATION
RELIGION
MARRIAGE

DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

NAME OF PHYSICIAN
NAME OF MINISTER
NAME OF CLERGYMAN

NAME OF WITNESSES
NAME OF CORONER
NAME OF JURY

NAME OF BURIAL PLACE
NAME OF CEMETERY
NAME OF FUNERAL HOME

NAME OF REGISTRAR
NAME OF CLERK
NAME OF ASSISTANT CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06461

Reg. Dist. No.

6485

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, 28, Md. | | c. LENGTH OF STAY IN TB 1 mo. 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | | | d. STREET ADDRESS 2303 W. North Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First George Last Amolsky | | | | 4. DATE OF DEATH Month 6 Day 18 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 19, 1882 | |
| | | | | 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Retail | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Louis Amolsky | | | | 14. MOTHER'S MAIDEN NAME Kate Seigel | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Spring Grove Hospital Catonsville, 28, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiovascular disease DUE TO dehydration Senility | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Geo M Kieffer M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED June 18, 58 | | | |
| EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 19/58 | | 22c. NAME OF CEMETERY OR CREMATORY Hebrew Frieddship | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE So. Leonard & Mrs. 1124-26 W. North Ave. | | | | 24a. REC'D BY REGISTRAR June 19 '58 | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 11 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6486

CERTIFICATE OF DEATH

Reg. Dist. No. 06462

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| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 5 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 3416 Esther Place | | | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle LAWSON Last APPLEGARTH | | | | 4. DATE OF DEATH Month June Day 11 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 11, 1885 | | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James L. Applegarth | | | | 14. MOTHER'S MAIDEN NAME Rose Stengel | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. WW-1 215-18-5494 | | 17. INFORMANT CLIN REC VET ADM HOSP FORT HOWARD MARYLAND Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.0 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last, (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 2 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA- 2 YRS. DURATION | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 6, 19 58 to June 11, 19 58 , and that death occurred at 7:55 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Fort Howard Maryland DATE SIGNED 6-11-58 | | | | | | | |
| ACTUAL SIGNATURE Samuel J. Mangus | | M.D. VAH Fort Howard Maryland | | DATE SIGNED 6-11-58 | | | |
| PHYSICIAN'S NAME (Type) SAMUEL J MANGUS | | M.D. VAH Fort Howard Maryland | | DATE SIGNED 6-11-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-16-58 | | 22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc ADDRESS | | | | 24a. REC'D BY REGISTRAR JUN 13 '58 | | 24b. REGISTRAR'S SIGNATURE Wm Cook-Blight | |

Wm.Cook-Blight Inc 6009 Harford Road Baltimore Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 10/57

CERTIFICATE OF DEATH

1911

Full Name

Age

Sex

Color

Marital Status

Place of Birth

Usual Residence

Occupation

Education

Religion

Usual Place of Abode

Usual Place of Death

Usual Place of Burial

Usual Place of Interment

Usual Place of Residence

Usual Place of Birth

Usual Place of Death

Usual Place of Burial

Usual Place of Interment

Usual Place of Residence

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6487

CERTIFICATE OF DEATH

Reg. Dist. 46463

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. 3V01-4 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home | | | | d. STREET ADDRESS 2259 Reisterstown Rd. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First WALTER Middle ELLSWORTH Last ATKINSON | | | | 4. DATE OF DEATH Month June Day 8, Year 19 58 | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec. 3, 1873 | |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman (rtd) | | | | 10b. KIND OF BUSINESS OR INDUSTRY Transit Co. | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME William R. Atkinson | | | | 14. MOTHER'S MAIDEN NAME Elizabeth E. Cook | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 213-10-1292 | | 17. INFORMANT Mr. Walter B. Atkinson - 6746 Glenkirk Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with 154X DUE TO widespread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from May 19, 1958 to June 7, 1958 that I last saw the deceased alive on June 7, 1958 and that death occurred at 7:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2108 Entwistle Place - Baltimore 17 Md. DATE SIGNED June 10 1958 | | | | | | | |
| ACTUAL SIGNATURE Morton M. Krieger M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) MORTON M. KRIEGER | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/10/58 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 10 58 | | 24b. REGISTRAR'S SIGNATURE W. J. Tickner | |

CERTIFICATE OF DEATH

1922

STATE OF MASS.

DEATH

MASSACHUSETTS

1922

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6488

CERTIFICATE OF DEATH

Reg. Dist. No.

06464

| | | | | | | | |
|--|----------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8026 Old Philadelphia Rd. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8026 Philadelphia Rd. Balto. Md. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Thomas Griffith Bamford | | | 4. DATE OF DEATH June 11 1958 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-23-84 | | 9. AGE (In years last birthday) 73 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY Steel | | 11. BIRTHPLACE (State or foreign country) Wales | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Bamford | | | | 14. MOTHER'S MAIDEN NAME Sarah Griffith | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213 05 0949A | | 17. INFORMANT Lillian B. Bamford Address 8026 Old. Phila. Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO (c) Carcinoma Rectum | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs 2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial asthma | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from Jan 1 1958 to June 11 1958 that I last saw the deceased alive on June 11 1958 , and that death occurred at 5:12 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE George Baumgardner M.D. | | | | ADDRESS (Street, city or town, state) Balto 6 Md | | | |
| PHYSICIAN'S NAME (Type) George Baumgardner | | | | DATE SIGNED 6/11/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-14-58 | | 22c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery | | 22d. LOCATION (City, town, or county) (State) Taylor Ave. Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc. 6009 Marford Rd. | | | | 24a. REC'D BY REGISTRAR DATE 6/12/58 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

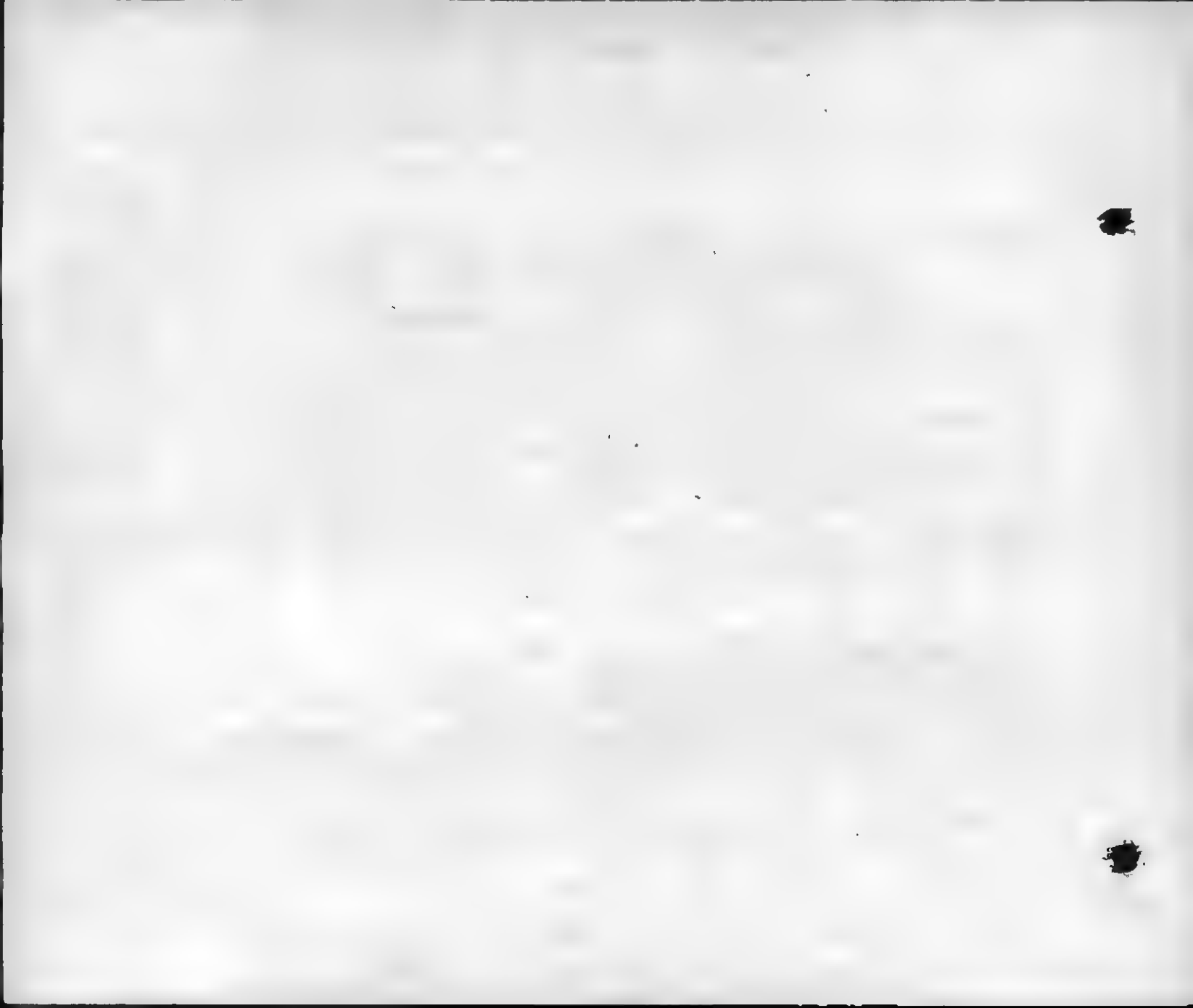
06465

Reg. Dist. No.

| | | | | | | | | | | | | | | | |
|---|--|--------------------------------------|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTC</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>18245 EASTERN AVE.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTC.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u> d. STREET ADDRESS <u>18245 EASTERN AVE.</u> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>LEUSE M. BARBER</u> First Middle Last | | | | 4. DATE OF DEATH <u>JUNE 10 1958</u> Month Day Year | | | | | | | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/21/1885</u> | | 9. AGE (In years last birthday) <u>72</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OFFIC</u> | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME <u>MYER</u> | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>318-07-6223A</u> | | | | 17. INFORMANT <u>HOWARD MYERS</u> | | | | Address <u>Above</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>422.1</u> DUE TO <u>A-S-C-V- Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca of Rectum</u> | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Flow</u> | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>M. B. Davis</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED <u>6/12/58</u> | | | | | | | |
| EXAMINER'S NAME (Type) <u>M. B. DAVIS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 22b. DATE THEREOF <u>6/12/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>CAK LAWN</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>BALTC.</u> <u>MD.</u> | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> | | | | | | ADDRESS <u> </u> | | | | 24a. REC'D BY REGISTRAR <u> </u> | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |
| DATE <u>JUN 12 '58</u> | | | | | | DATE <u>JUN 12 '58</u> | | | | | | | | | |

MEDICAL CERTIFICATION

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6490

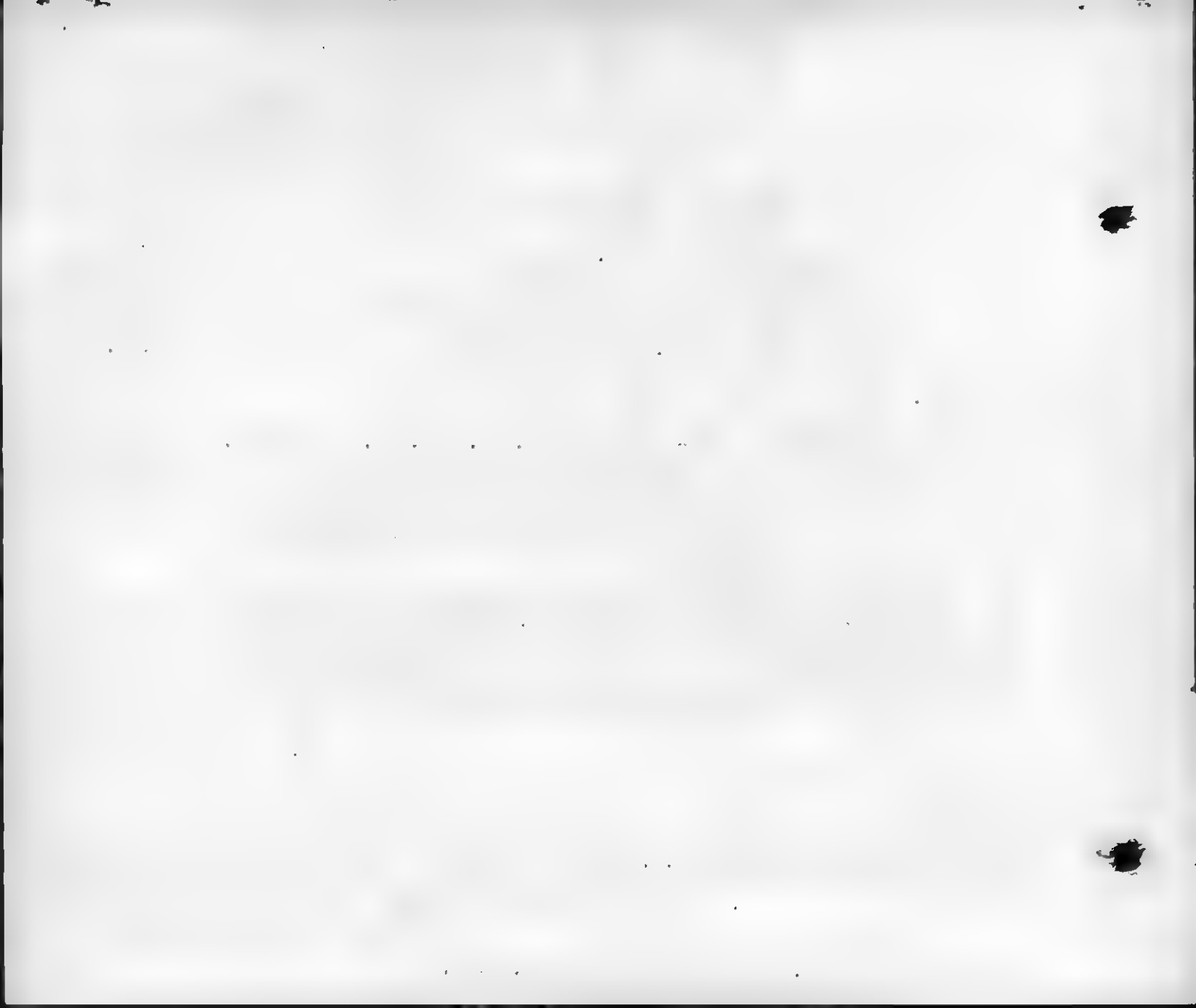
CERTIFICATE OF DEATH

06466

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 36 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster (Rural) | |
| 3. NAME OF DECEASED (Type or print) First ERNEST Middle F. Last BARNES | | 4. DATE OF DEATH Month June Day 10 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21, 1904 |
| 9. AGE (In years last birthday) 54 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Revenue Agent | |
| 11. BIRTHPLACE (State or foreign country) Danvers, Massachusetts | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John F. Barnes | | 14. MOTHER'S MAIDEN NAME Martha Taplin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes Peace Time | | 16. SOCIAL SECURITY NO. 578-10-5835 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT LOWER LOBE DUE TO CARCINOMA, LEFT LUNG, RESECTED, METASTATIC TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MEDIASTINUM DUE TO (c) | | INTERVAL BETWEEN ONSET OF DISEASE AND DEATH 10 DAYS UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation - Pneumonectomy - November 2, 1954 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 5, 1958 to June 10, 1958 and that death occurred at 9:05 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 6/10/58 | | | |
| ACTUAL SIGNATURE C. Fitch | | PHYSICIAN'S NAME (Type) CHARLES T. FITCH, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-13-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. | | 24a. REC'D BY REGISTRAR DATE JUN 13 '58 | |
| 24b. REGISTRAR'S SIGNATURE Wm Cook - Blight, Inc., 6009 Harford Rd., Balto. 14, Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6491

CERTIFICATE OF DEATH

Reg. Dist. No.

06467

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN | | | |
| c. LENGTH OF STAY IN TB 10 Mo. | | | | d. STREET ADDRESS 14 SUMMERFIELD RD. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Daughter's home) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELMER ROSS BAY | | | | 4. DATE OF DEATH Month Day Year JUNE 28, 1958 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 27, 1865 | |
| 9. AGE (In years last birthday) 92 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER | | 10b. KIND OF BUSINESS OR INDUSTRY AGRI. | | 11. BIRTHPLACE (State or foreign country) HARFORD CO., MD. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME KENNEDY BAY | | | | 14. MOTHER'S MAIDEN NAME MARY ENFIELD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) No | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Address MRS. WALTER WILHELM, DELTA, PA. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 4:00.0 DUE TO atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Posterior ischemic heart dis. (c) 6 y. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 15 d. 6 y. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from October 1957 to 6/28, 1958 , that I last saw the deceased alive on 6/28, 1958 , and that death occurred at 4:45 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Christian S. Mass | | | | ADDRESS (Street, city or town, state) 111 E. Ch. Ave, Baltimore, Md. | | | |
| PHYSICIAN'S NAME (Type) CHRISTIAN S. MASS | | | | DATE SIGNED 6/28/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 7-1-58 | | 22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE | | 22d. LOCATION (City, town, or county) (State) DELTA, PENNA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison | | | | ADDRESS Delta, Pa. | | 24a. REC'D BY REGISTRAR DATE JUL 1 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6492

CERTIFICATE OF DEATH

06468

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 21 Hrs. 19 M. d. NAME OF HOSPITAL (If not in hospital, give street address, OR INSTITUTION) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 828 West 32nd Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) (Served) EARL (NMI) F. BELL | | 4. DATE OF DEATH Month June Day 5 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 14, 1900 |
| 9. AGE (In years last birthday) 58 | | 10. IF UNDER 1 YEAR Months 5 Days 5 Hours 19 Min. 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roller Helper | | 10b. KIND OF BUSINESS OR INDUSTRY Biscuit Company | |
| 11. BIRTHPLACE (State or foreign country) Pittsburgh, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Frank Bell | | 14. MOTHER'S MAIDEN NAME Emma Burnhart | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I | | 16. SOCIAL SECURITY NO. 216-01-9066 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO COR PULMONALE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO PULMONARY EMPHYSEMA DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA, LEFT LOWER LOBE * Duration 5 Days | | INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 1 YEAR 6 YEARS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) AM | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 4-11:00 19 58 , to June 6, 19 58 , and that death occurred at 8:19 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE I. Freeman | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | |
| PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical Service | | DATE SIGNED 6/5/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 9, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mount Zion Cemetery | | 22d. LOCATION (City, town, or county) (State) Mt. Zion Church, Baltimore Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank Seitz Funeral Home, Baltimore, Maryland | | 24a. REC'D BY REGISTRAR June 9 58 | |
| 24b. REGISTRAR'S SIGNATURE W. H. Seitz | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

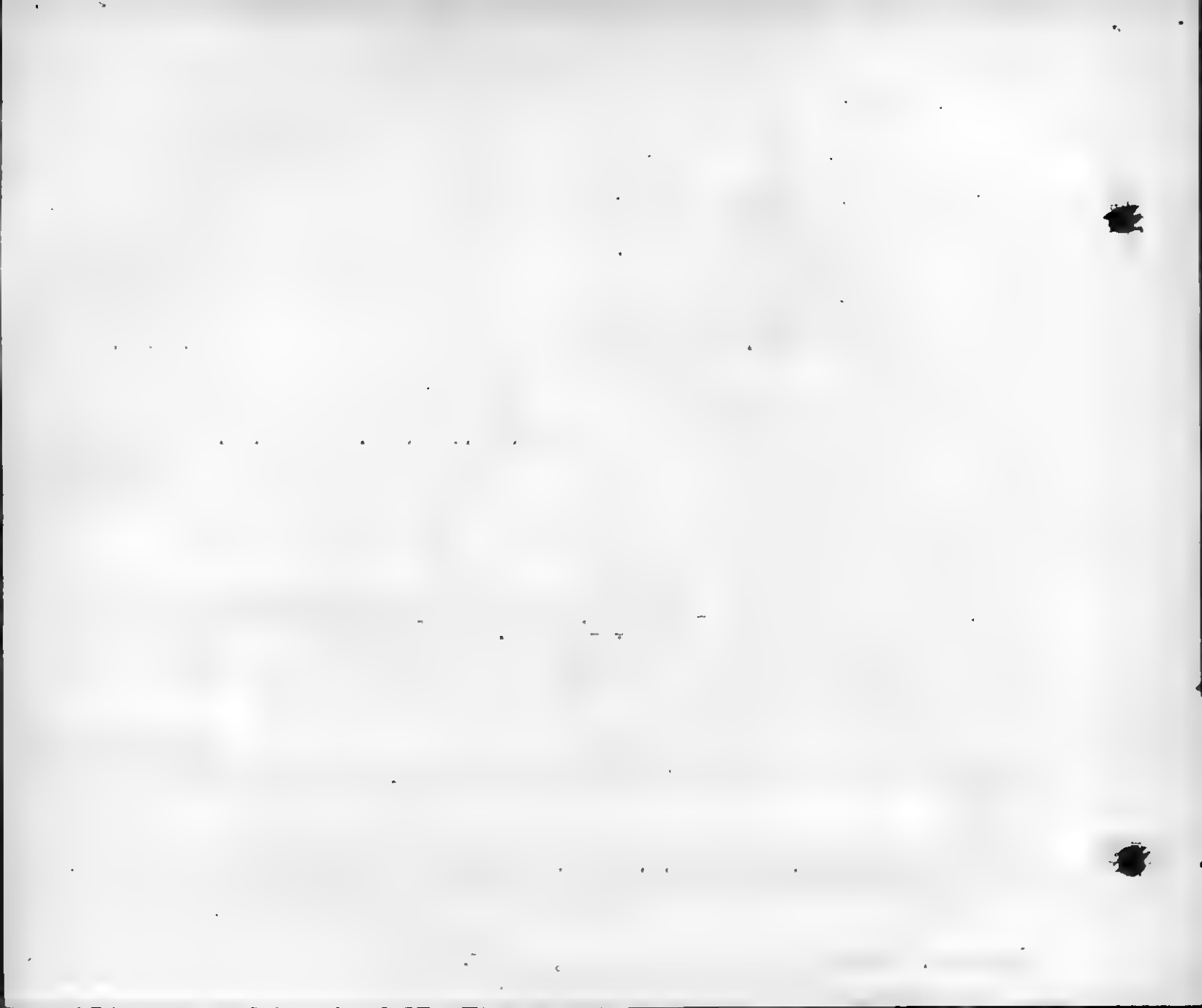
6493

CERTIFICATE OF DEATH

Reg. Dist. No. 06469

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before adm ssion) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 8 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | |
| f. STREET ADDRESS Box 32 | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First SIDNEY Middle A. Last BELL | | 4. DATE OF DEATH Month June Day 4 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH September 13, 1918 |
| 9. AGE (In years last birthday) 39 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | 11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck-Driver, self empl. | | 10b. KIND OF BUSINESS OR INDUSTRY Produce Hauling | |
| 11. BIRTHPLACE (State or foreign country) Cambridge, Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Sidney P. Bell | | 14. MOTHER'S MAIDEN NAME Ethel Horner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO 271 67 9494 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Cerebral Arteriogram - 6/2/58 2. Left Sub-temporal decompression and removal of tissue for biopsy - 6/3/58. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from May 27 , 19 58 , to June 4 , 19 58 , and that death occurred at 2:40 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 6/4/58 SIGNATURE Joseph M. Miller PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service, V.A.H., FORT HOWARD, MARYLAND 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6-6-58 22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park 22d. LOCATION (City, town, or county) (State) Cambridge, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Home ADDRESS Cambridge, Maryland 24a. REC'D BY REGISTRAR JUN 10 '58 24b. REGISTRAR'S SIGNATURE Alfred Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6494

CERTIFICATE OF DEATH

Reg. Dist. No. 06470

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) b. COUNTY Balto. Co. 7324 Kirtley Rd. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate | | c. LENGTH OF STAY IN Tb 12yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS 17324 Kirtley Road 24 | |
| 3. NAME OF DECEASED (Type or print) First Evelyn Middle M. Last Beyer | | 4. DATE OF DEATH Month June Day 22 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIAGE STATUS NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 7, 1923 |
| 9. AGE (In years lost birth day) yrs. 35 | | 10. IF UNDER 1 YEAR Months 3 Days 15 Hours 40 Min 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboratory work | | 10b. KIND OF BUSINESS OR INDUSTRY Romashoss & Co. | |
| 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Frank Wilkinson | | 14. MOTHER'S MAIDEN NAME Mabel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- | | 16. SOCIAL SECURITY NO 194-12-3500 | |
| 17. INFORMANT Lawrence Beyer | | Address 7324 Kirtley Road 24 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac, general carcinoma DUE TO carcinoma of cervix uteri Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- (c) --- | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 3, 1957 to June 22, 1958 , that I last saw the deceased alive on June 21, 1958 , and that death occurred at 6:45 p. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. C. Tobial | | ADDRESS (Street, city or town, state) 447 N. Kenwood Ave. | |
| PHYSICIAN'S NAME (Type) L. C. Tobial | | DATE SIGNED June 25 '58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 26/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY U.S. National Cem. | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig, Son, 2024 Orleans St. | | 24a. REC'D BY REGISTRAR June 25 '58 | |
| 24b. REGISTRAR'S SIGNATURE 2024 Orleans St. | | | |

VS A15 (4)
15M 10/57

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

Item 18 Film 28 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06471

Reg. Dist. No.

| | | | |
|--|---------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If first listed - Residence before admission) a. STATE <u>W. Va</u> b. COUNTY <u>Mener County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATASKVILLE</u> | | c. LENGTH OF STAY IN 1b <u>6 HRS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING CROVE STATE HOS</u> | | d. STREET ADDRESS <u>Pin oak W. Va</u> | |
| 3. NAME OF DECEASED (Type or print) <u>HERBERT BIGGS</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9/16/1922</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Mining Industry</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Mener County W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 13. FATHER'S NAME <u>Thomas D. Biggs</u> | | 14. MOTHER'S MAIDEN NAME <u>Elsie Lusk</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>RECORDS OF Hospital</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>322.1</u> DUE TO <u>Branchial asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Delirium tremens</u> (c) <u>Acute Chronic alcoholism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Geo M Kieffer</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>GEO. S. M KIEFFER</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Family Plot</u> | | 22b. DATE THEREOF <u>7/5/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mener County W. Va</u> | | 22d. LOCATION (City, town, or county) (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Barley & Sons</u> | | ADDRESS <u>Princeton W. Va.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE JUL 2 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> | |

DATE SIGNED

JUNE 29 1958



6496

CERTIFICATE OF DEATH

Reg. Dist. No.

06472

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Railroad Ave.</u> | | d. STREET ADDRESS <u>Railroad Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur F. Franklin Blizard</u> | | 4. DATE OF DEATH Month Day Year <u>June 5 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 22 78</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md</u> |
| 13. FATHER'S NAME <u>John Blizard</u> | | 14. MOTHER'S MAIDEN NAME <u>Carrie Kemp</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Carrie Joe-daughter, and</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardiovascular disease 10 yrs</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>3 June 1958</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Walter J. Blizard</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Cockeysville 5 June 58</u> | |
| PHYSICIAN'S NAME (Type) <u>Walter J. Blizard</u> | | <u>Cockeysville Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6-9-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Gilead</u> | 22d. LOCATION (City, town, or county) (State) <u>Woodensburg, Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brock</u> | | ADDRESS <u>622 York Rd., Towson 4, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>June 10 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. J. Blizard</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6497

CERTIFICATE OF DEATH

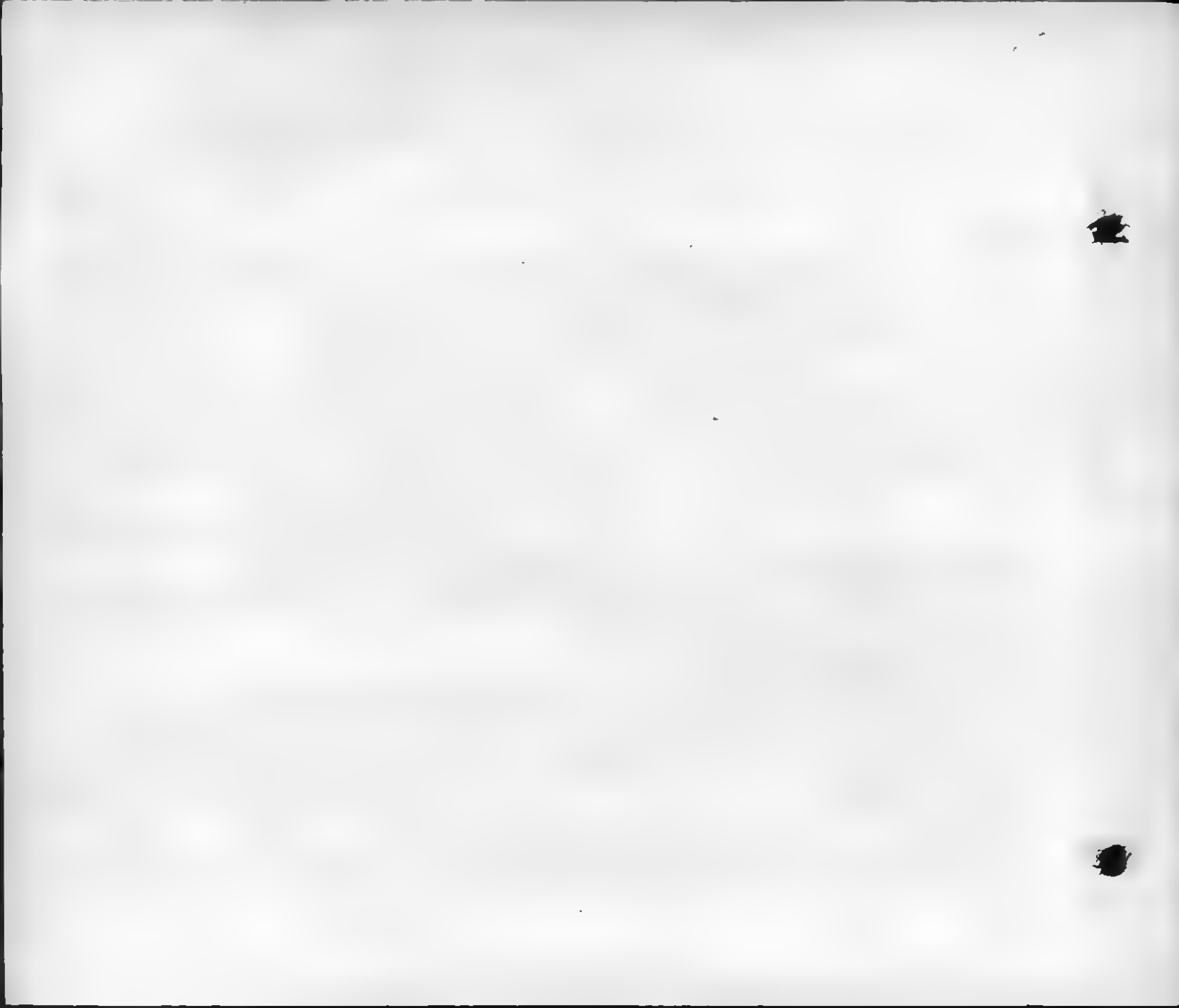
06473

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ■ STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO 7</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 7</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOGWOOD ROAD.</u> | | e. STREET ADDRESS <u>DOGWOOD ROAD</u> | |
| 3. NAME OF DECEASED (Type or print) <u>SUSAN CATHERINE BOWERS</u> | | 4. DATE OF DEATH <u>JUNE 2 1958</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 22-1890</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOMEKEEPING</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>JOSHUA MULLINIX</u> | | 14. MOTHER'S MAIDEN NAME <u>AMELIA DAVIS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>216-07-6926</u> | |
| 17. INFORMANT <u>MRS HENRY BECKER - Dogwood Rd -</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT -</u> DUE TO <u>HYPERTENSIVE C.V. DISEASE, &</u> DUE TO <u>RENAL INSUFFICIENCY -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>10 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>JUNE 1 1958</u> to <u>JUNE 2 1958</u> that I last saw the deceased alive on <u>JUNE 2 1958</u> and that death occurred at <u>3601 CLIFMAR RD - 7 - 6/2/58</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D. | | ADDRESS (Street, city or town, state) <u>3601 CLIFMAR RD - 7 - 6/2/58</u> | |
| PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>6-5-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u> | 22d. LOCATION (City, town, or county) (State) <u>Randallstown 172</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higginbotham</u> | | 24a. REC'D BY REGISTRAR <u>Elliot City, Md</u> | |
| 24b. REGISTRAR'S SIGNATURE | | DATE <u>6-5-58</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6498

CERTIFICATE OF DEATH

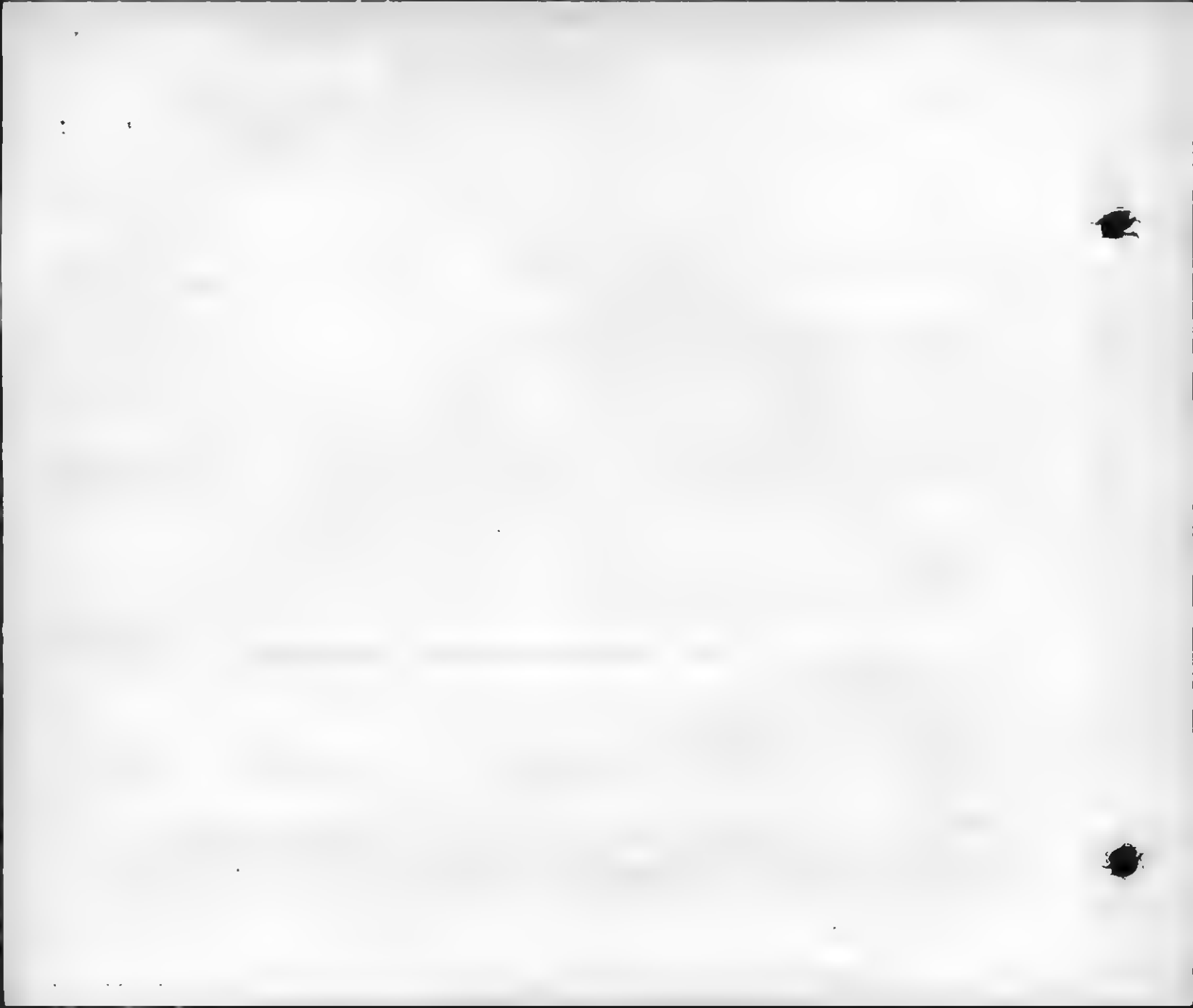
Reg. Dist. No.

06474

| | | | |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ruxton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>1018 WAGNER Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>E. GILLET BOYCE</u> | | 4. DATE OF DEATH <u>June 6 1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 9 1911</u> |
| 9. AGE (In years last birthday) <u>46 yrs</u> | | 10. IF UNDER 1 YEAR: Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>W. Graham Boyce</u> | | 14. MOTHER'S MAIDEN NAME <u>Elise Gillet</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>214-24-0108</u> | |
| 17. INFORMANT <u>Mrs E. Gillet Boyce</u> | | Address <u>Arme</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ischemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pylonephritis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 28, 1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>1:04 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William F. Pearce</u> M.D. | | ADDRESS (Street, city or town, state) <u>2105 N. Charles St Baltimore 18 Md</u> | |
| PHYSICIAN'S NAME (Type) <u>WILLIAM F. PEARCE</u> | | DATE SIGNED <u>4/6/58</u> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Cremation</u> | | 22b. DATE THEREOF <u>June 7 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Ashwood</u> | | 22d. LOCATION (City, town, or county) (State) <u>Croftsville Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Finkbeiner & Sons Co</u> | | ADDRESS <u>4905 York Rd</u> | |
| 24a. REC'D BY REGISTRAR <u>JUN 9 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form must be signed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

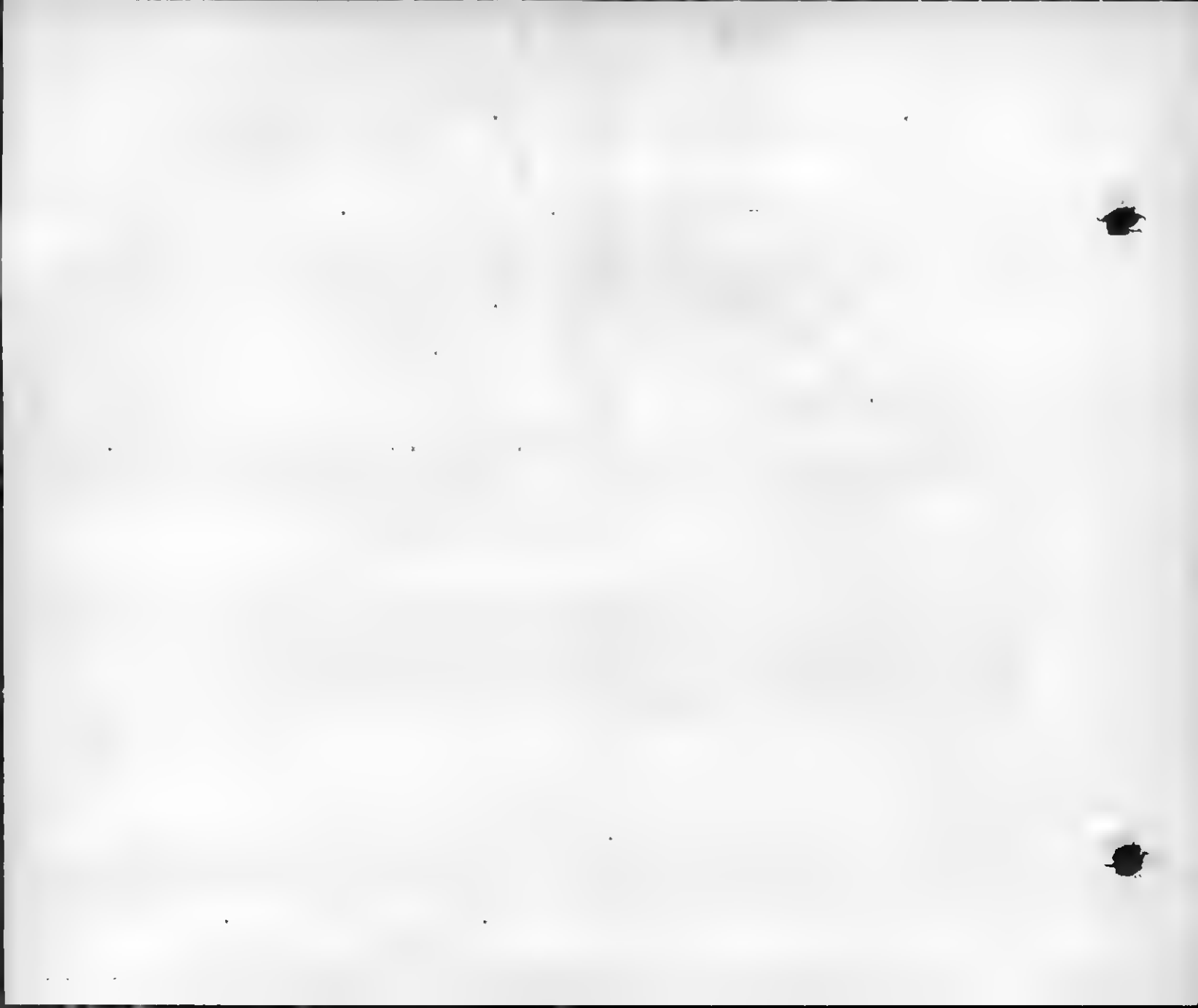
6499

CERTIFICATE OF DEATH

06475

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a COUNTY Balto. MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a STATE Md. b COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b Baltimore | |
| d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wayne Nursing Home-98 Smithwood Ave. | | d. STREET ADDRESS 2601 Oakley Ave. | |
| 3. NAME OF DECEASED (Type or print) First CORDELIA Middle MILDRED Last BULL | | 4. DATE OF DEATH Month June Day 25 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Jan. 26, 1872 |
| 9. AGE (In years last birthday) 86 yrs | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY at home | 11 BIRTHPLACE (State or foreign country) Md. |
| 12 CITIZEN OF WHAT COUNTRY? | | 13 FATHER'S NAME George W. Berry | |
| 14 MOTHER'S MAIDEN NAME Margaret Delcher | | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service) | |
| 16 SOCIAL SECURITY NO none | | 17 INFORMANT Mr. Ralph H. Amrein - 2511 Oakley Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Failure to take medicine DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Asphyxiated by carbon monoxide from gas heater | |
| 20c. TIME OF INJURY Month, Day, Year Hour 5 m. MAY 19 58 p. m. | 20d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) Baltimore Md. |
| 21. I certify that I attended the deceased from Home , 19 58 , to June 25, 1958 , that I last saw the deceased alive on June 25, 1958 , and that death occurred at 10:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John J. Lickner | | ADDRESS (Street, city or town, state) 6499 Woodlawn Ave. Baltimore, Md. | |
| PHYSICIAN'S NAME (Type) John J. Lickner | | DATE SIGNED June 27 1958 | |
| 22a BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/28/58 | 22c NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. |
| 23 FUNERAL DIRECTOR'S SIGNATURE John J. Lickner | | 24a REC'D BY REG STRAR John J. Lickner | |
| ADDRESS 6499 Woodlawn Ave. Baltimore, Md. | | 24b REGISTRAR'S SIGNATURE John J. Lickner | |



6500

CERTIFICATE OF DEATH

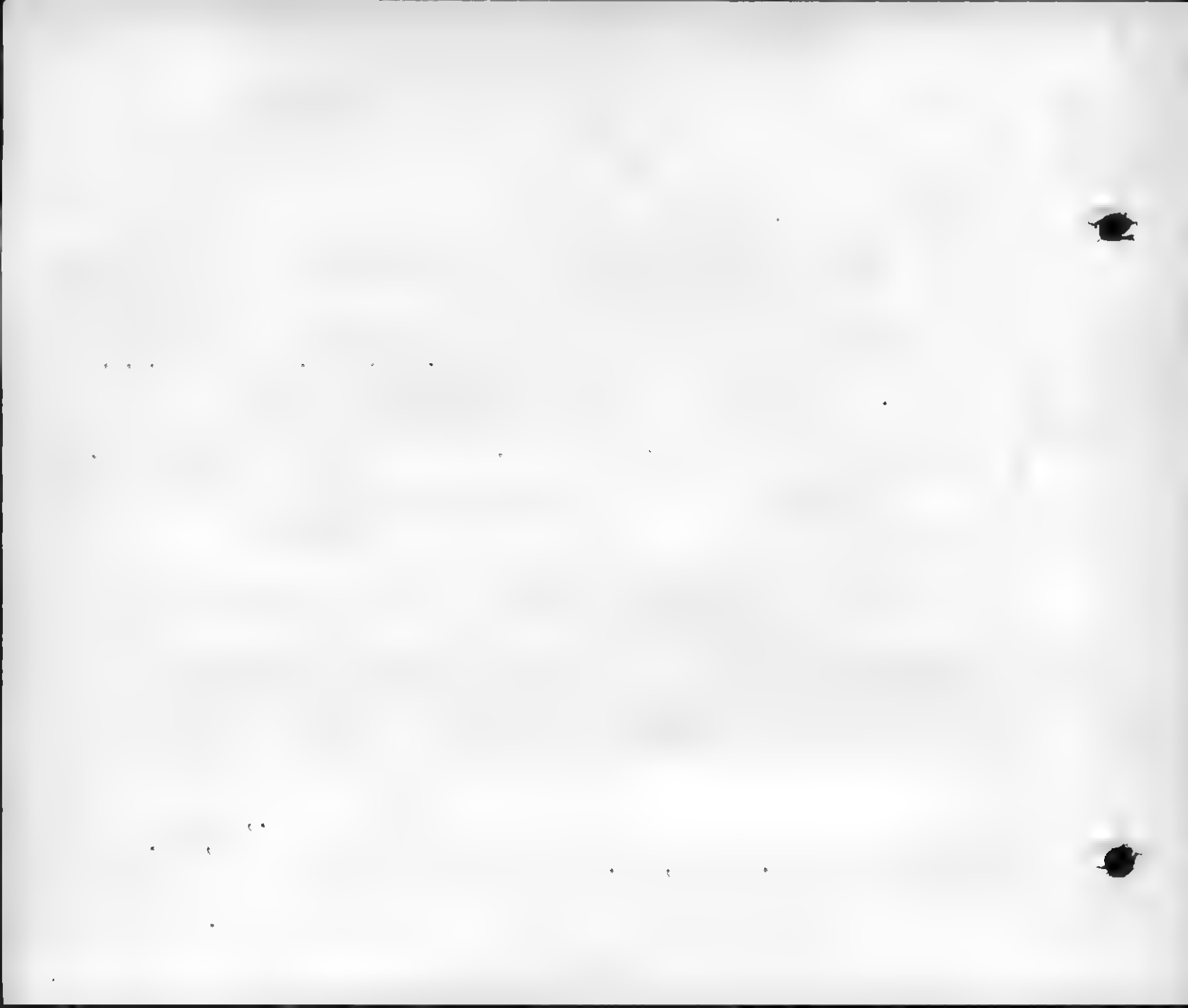
Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2901 Chenoak Ave.</u> | | d. STREET ADDRESS <u>2901 Chenoak Ave.</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Charles Raymond Chenoweth</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 15 1900</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs | | 10. IF UNDER 1 YEAR Months Days Hours /Ain. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Store</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto., Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John G. Chenoweth</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E Fuller</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-22-7523</u> | |
| 17. INFORMANT <u>Mrs. Hazel Chenoweth</u> | | Address <u>2901 Chenoak Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>162.1</u> DUE TO <u>Primary Lung Ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis to Brain</u> (c) <u>Tracheobronchitis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Just detected in April 1958</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchiectasis old</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 16 1958</u> to <u>June 27 1958</u> , that I last saw the deceased alive on <u>June 16 1958</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> | | ADDRESS (Street, city or town, state) DATE SIGNED <u>9005 Harford Rd., Baltimore</u> <u>14, Md. 6/28/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Frank T. Kasik, Jr.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-30-1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Stessahn Fun'l Home Inc. 744 Belair Rd</u> | | ADDRESS <u>744 Belair Rd</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JUN 20 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6501

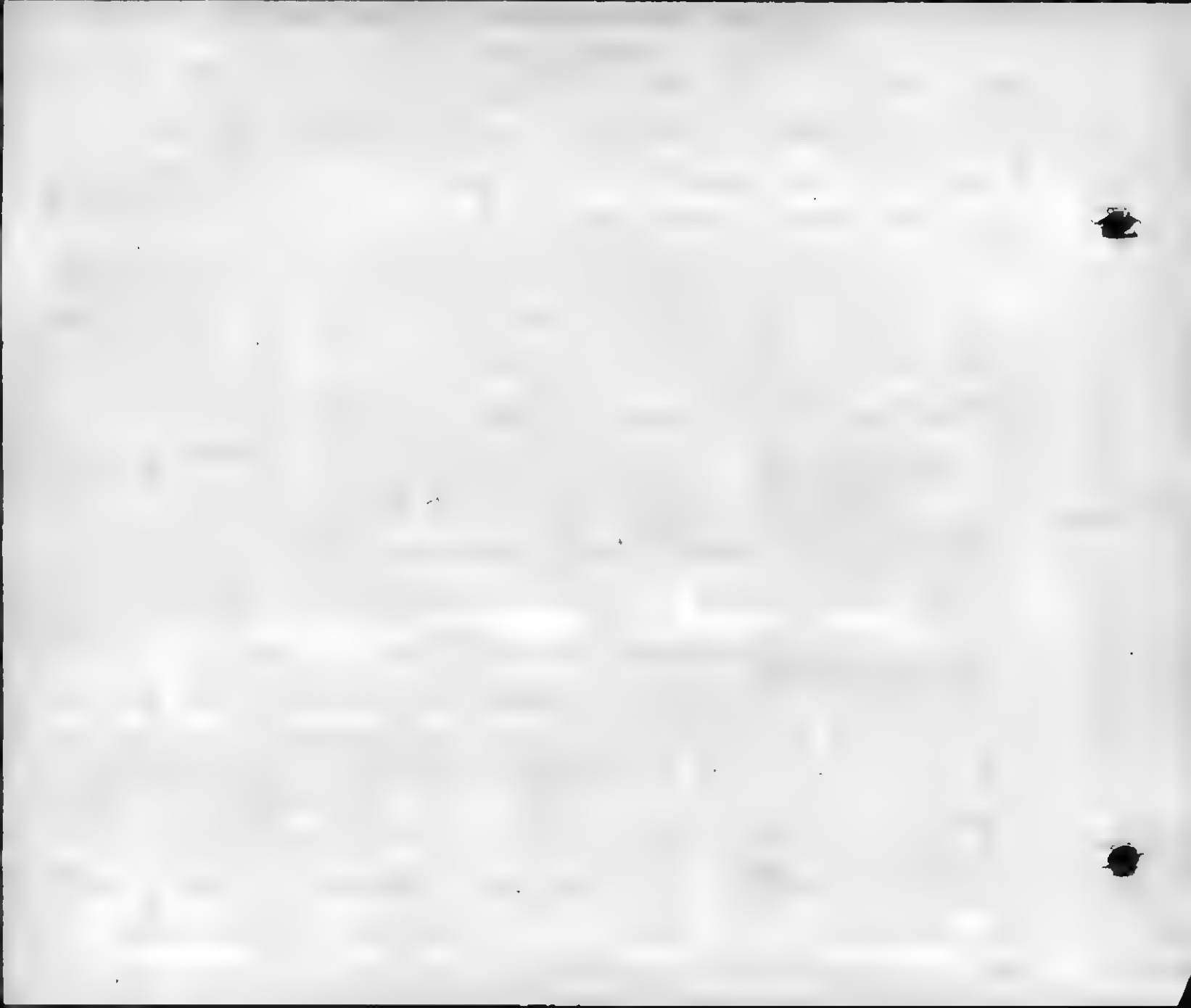
CERTIFICATE OF DEATH

Reg. Dist. 46477

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>CITY - Zone 6</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3Y01-4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>My Hall Nursing Home</u> | | d. STREET ADDRESS <u>5409 Mayview - Zone 6</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>Elizabeth</u> Last <u>Chlada</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/20/1905</u> |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u> | IF UNDER 24 HRS Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George BENNER</u> | | 14. MOTHER'S MAIDEN NAME <u>FANNIE Elizabeth POTE</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>MR. Ambrose J Chlada</u> | | Address <u>Stars</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wernia</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u></u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Arteriosclerosis</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> | 20f. (City or town) (County) (State) <u></u> |
| 21. I certify that I attended the deceased from <u>February 1958</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>6 P.M.</u> , 1958, and that death occurred at <u>6:52</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Samuel Stern, M.D.</u> | | ADDRESS (Street, city or town, state) <u>Ridge Rd.</u> | |
| DATE SIGNED <u>6/21/58</u> | | | |
| NAME (Type) <u>SAMUEL STERN, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-28-58</u> | 22b. DATE THEREOF <u>6-28-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuck</u> | | ADDRESS <u>1305 Hayford</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6502

CERTIFICATE OF DEATH

Reg. Dist. No. 06478

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7811 Telford</u> | | d. STREET ADDRESS <u>7811 Telford</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Christian K. Claypoole</u> | | 4. DATE OF DEATH <u>June 28 1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-21-1898</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Colonel Army</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTH PLACE (State or foreign country) <u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Harry Claypoole</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Smuold</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>yes</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>213-09-0880</u> | |
| 17. INFORMANT <u>Mrs Martha A. Claypoole</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute: Adams Stokewell</u> DUE TO <u>Old Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 1952</u> to <u>June 1958</u> , that I last saw the deceased alive on <u>May 16 1958</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank T. Kasik Jr</u> M.D. | | ADDRESS (Street, city or town, state) <u>6205 Harford Rd Baltimore Md</u> | |
| PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR</u> | | <u>BAITO 14 Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6502</u> | 22b. DATE THEREOF <u>7-2-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | 22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lemond Duke</u> ADDRESS <u>5305 Harford</u> | | 24a. REC'D BY REGISTRAR <u>DATE JUL 1 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>W. Smith</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

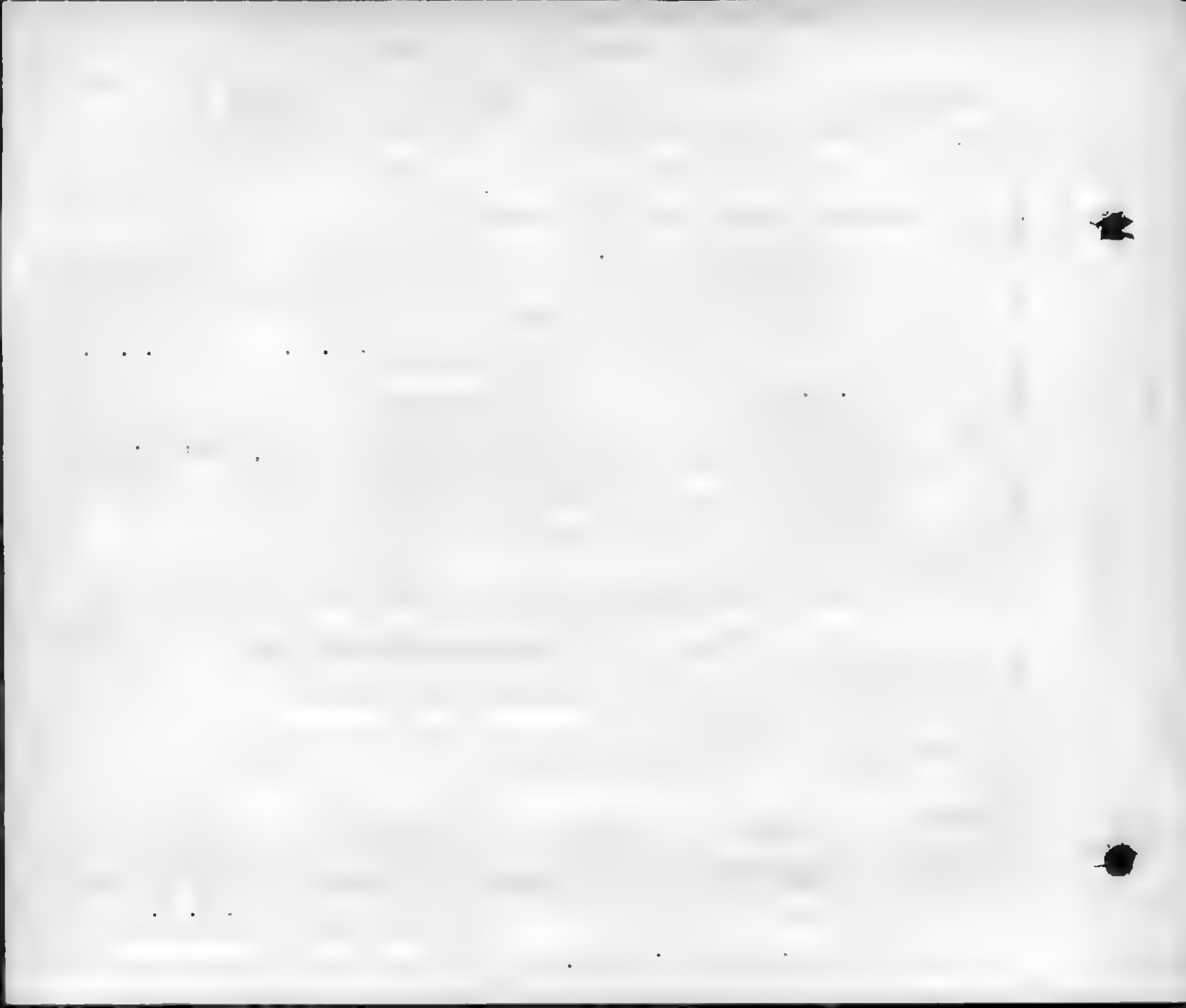
6503

CERTIFICATE OF DEATH

06479

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase,</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d STREET ADDRESS <u>None</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Sidney</u> Middle <u>A.</u> Last <u>Coon</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/22/77</u> | | 9. AGE (In years last birthday) <u>81</u> yrs | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Hawleyton, N. Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u> | |
| 13. FATHER'S NAME <u>Peter J. S. Coon</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Jane</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs Bertha Gage</u> | | Address <u>Chase, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p. m. <u> </u> 19 <u>58</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>58</u> , to <u>June 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>58</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Irving R Beck</u> | | | | ADDRESS (Street, city or town, state) <u>901 Fauselsgate w. Baltimore 20 md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>IRVING R. BECK, M.D.</u> | | | | DATE SIGNED | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>6/11/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Chenango Valley Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Binghamton, N. Y.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook Inc.</u> | | | | ADDRESS <u>1217 St. Paul St., Baltimore, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Alberich</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6504

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Aintree Road | | d. STREET ADDRESS 8 Aintree Road #4 | |
| 3. NAME OF DECEASED (Type or print) First A. J. Middle WINIFRED Last CROMWELL | | 4. DATE OF DEATH Month June 19, Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 18, 1886 |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John McPhail | | 14. MOTHER'S MAIDEN NAME Anne | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO Yes | |
| 17. INFORMANT Mr. Robert Cromwell-6455 Blenheim Road #12 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 years DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1946 to 19 June 1958 , that I last saw the deceased alive on 19 June 1958 , and that death occurred at 9 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Charles H. Reier | | ADDRESS (Street, city or town, state) 6701 York Rd Baltimore Md 21206 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/21/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Pikesville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Pickens ADDRESS Beth-17, Md. | | 24a. REC'D BY REGISTRAR JUN 23 '58 24b. REGISTRAR'S SIGNATURE Allyesuech | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

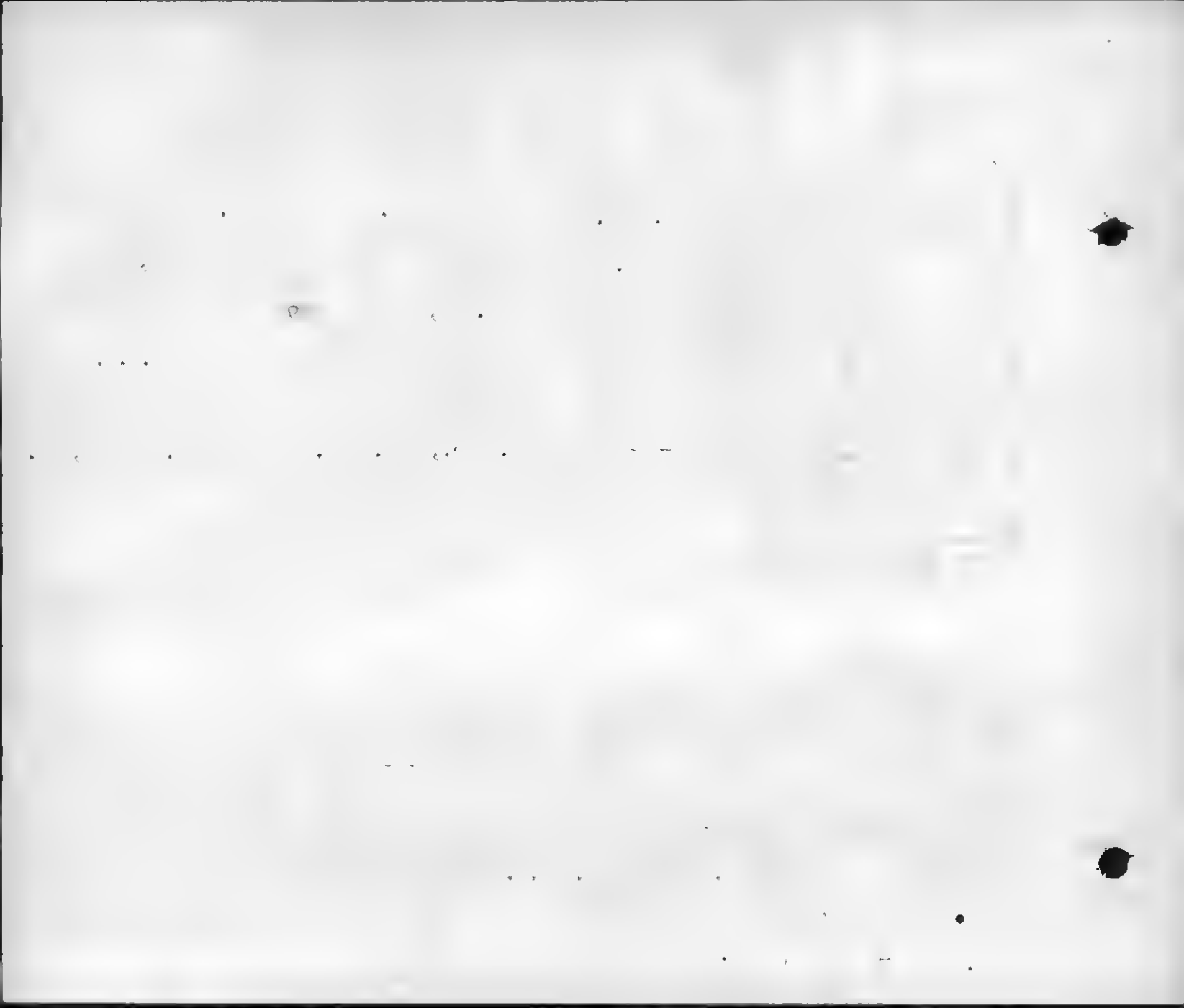


1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6505

Reg. Dist. No. 06481

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN lb 56 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fort Howard Hospital Vet. Adm. | | | | d. STREET ADDRESS 801 E. Lexington St. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RICHARD D. CROUCH | | | | 4. DATE OF DEATH Month Day Year June 30, 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 12, 1909 | | 9. AGE (In years last birthday) 49 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Building | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Crouch | | | | 14. MOTHER'S MAIDEN NAME Lula Griffin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 243 -10- 9361 | | 17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital Ft. Howard, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 983X Malnutrition due to head injury DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pushed down flight of stairs | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2/21/58 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Baltimore | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 7/1/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 7/1/58 | | 22c. NAME OF CEMETERY OR CREMATORY Farmers Cemetery | | 22d. LOCATION (City, town, or county) (State) Farmers North Carolina | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook - Blight, Inc. | | | | ADDRESS 6009 Harford Road | | 24a. REC'D BY REGISTRAR DATE JUN 7 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Overland | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06482

Reg. Dist. No.

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTO. Co. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MP b. COUNTY BALTO | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Graceland Park | | c. LENGTH OF STAY IN 1b 40 YRS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 603 WILSON AVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ELI CUTAN | | 4. DATE OF DEATH Month 6 Day 2 Year 1958 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1893 |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months 6 Days 2 | IF UNDER 24 HRS. Hours 2 Min. 58 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIP FITTER | | 10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD | |
| 11. BIRTHPLACE (State or foreign country) ROMANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES CUTAN | | 14. MOTHER'S MAIDEN NAME MARY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 25-01-3211 | |
| 17. INFORMANT JOHN CUTAN | | Address 603 WILSON AVE | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 hr DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Jack Collins | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) JACK C COLLINS | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED 6-2-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/5/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary | | 22d. LOCATION (City, town, or county) (State) Balto. Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski | | ADDRESS 2007 Eastern Ave | |
| 24a. REC'D BY REGISTRAR W. S. Fialkowski | | 24b. REGISTRAR'S SIGNATURE W. S. Fialkowski | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in I 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



6465

CERTIFICATE OF DEATH

06483

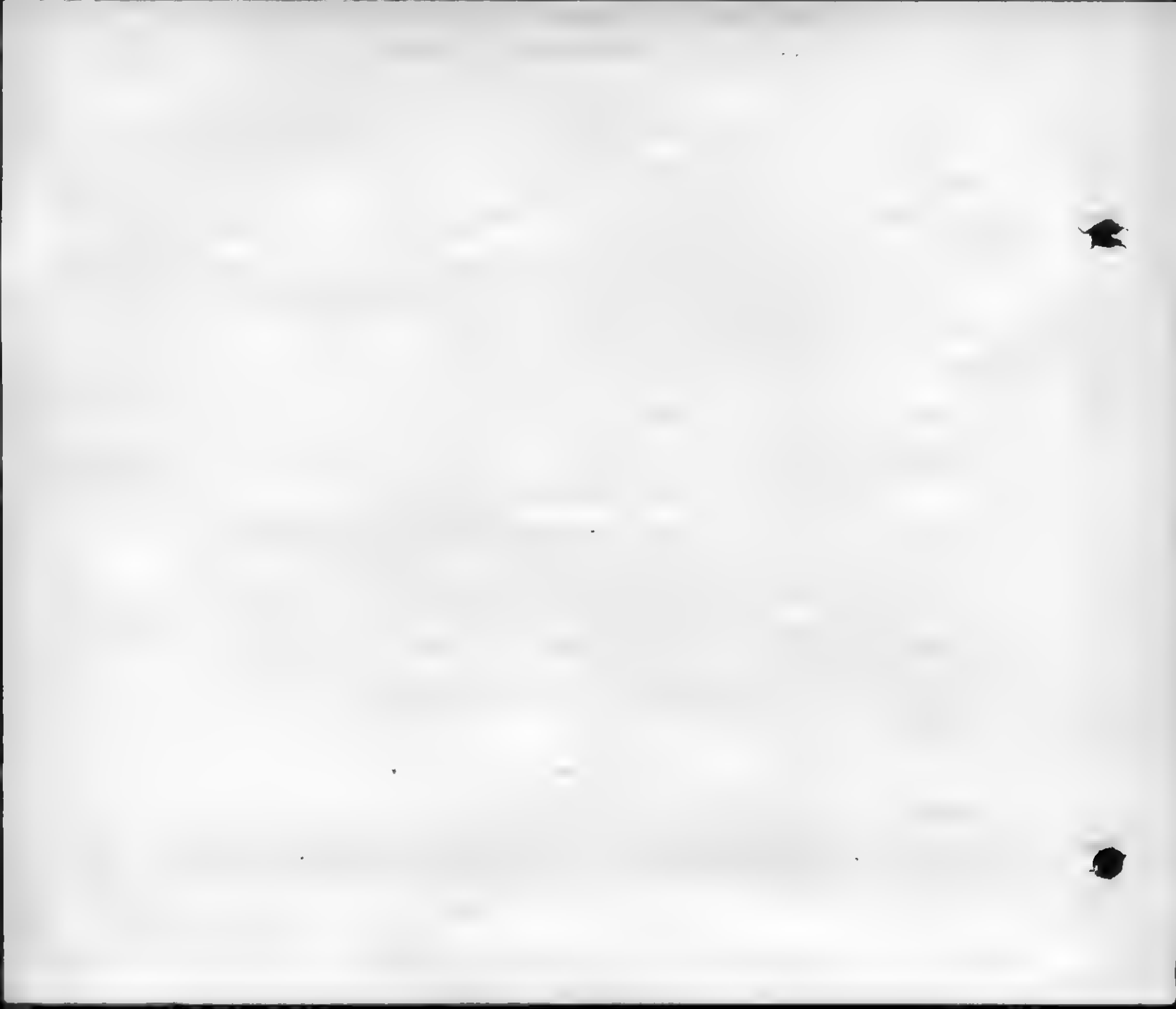
Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> | | | | c. LENGTH OF STAY IN 1b <u>40 YRS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>56 SHIPWAY</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>DAIL</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1958</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 2, 1880</u> | |
| 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE, Maryland</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>URIAH B. Willey</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY E. ADAMS</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | | |
| 17. INFORMANT <u>JACK DAIL JR.</u> | | | | Address <u>15 TOWNSHIP Rd. DUNDALK</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> | | | | | | | |
| DUE TO <u>440X</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| (b) <u>Arteriosclerotic hypertensive cardiovascular disease</u> | | | | | | | |
| DUE TO <u> </u> | | | | | | | |
| (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>31 May</u> , 19 <u>58</u> , to <u>6 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6 June</u> , 19 <u>58</u> , and that death occurred at <u>1 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) DATE SIGNED <u>6 June 1958</u> | | | | | | | |
| ACTUAL SIGNATURE <u>W. E. Baermann</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>W. E. BAERMANN, M.D.</u> 33 Dundalk Avenue, Dundalk 22, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 22b. DATE THEREOF <u>6/9/58</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN Cemetery</u> | | | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brack's Bralleys Inc</u> | | | | ADDRESS <u>Dundalk, Md.</u> | | | |
| 24a. REC'D BY REGISTRAR <u> </u> | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |
| DATE <u>JUN 10 '58</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06484

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>FLORIDA</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Hereford</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. Petersburg</u> | |
| c. LENGTH OF STAY IN 1b <u>0</u> | | d. STREET ADDRESS <u>1226 Second Ave. N.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>York Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William Henry Daniels</u> | | 4. DATE OF DEATH <u>JUNE 28 1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>B</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 3, 1905</u> |
| 9. AGE (In years last birthday) <u>53 yrs</u> | | 10. IF UNDER 1 YEAR Months Days | |
| 11. IF UNDER 24 HRS. Hours M n. | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MAKELAND, C.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wm H. Daniels</u> | | 14. MOTHER'S MAIDEN NAME <u>Fannie Serrano</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>255-223383</u> | |
| 17. INFORMANT <u>Mr. W. H. Daniels, 1226 2nd Ave. N., St. Petersburg Fla.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENTIRE body charred by fire</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | |
| b. <u>8:22 P.M.</u> DUE TO | | | |
| c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Truck which was backing over driveway & caught on fire. He burned without it</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>6/28 1958</u> | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 111</u> | | 20f. (City or town) <u>Hereford Balto., Md.</u> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> | | DATE SIGNED <u>6/28/58</u> | |
| EXAMINER'S NAME (Type) <u>A. M. FRANCE</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>July 2, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom, Pa.</u> | | 22d. LOCATION (City, town, or county) (State) <u>St. Petersburg, Fla.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartman</u> | | 24a. REC'D BY REGISTRAR <u>Al Leach</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <u>2 '58</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6477

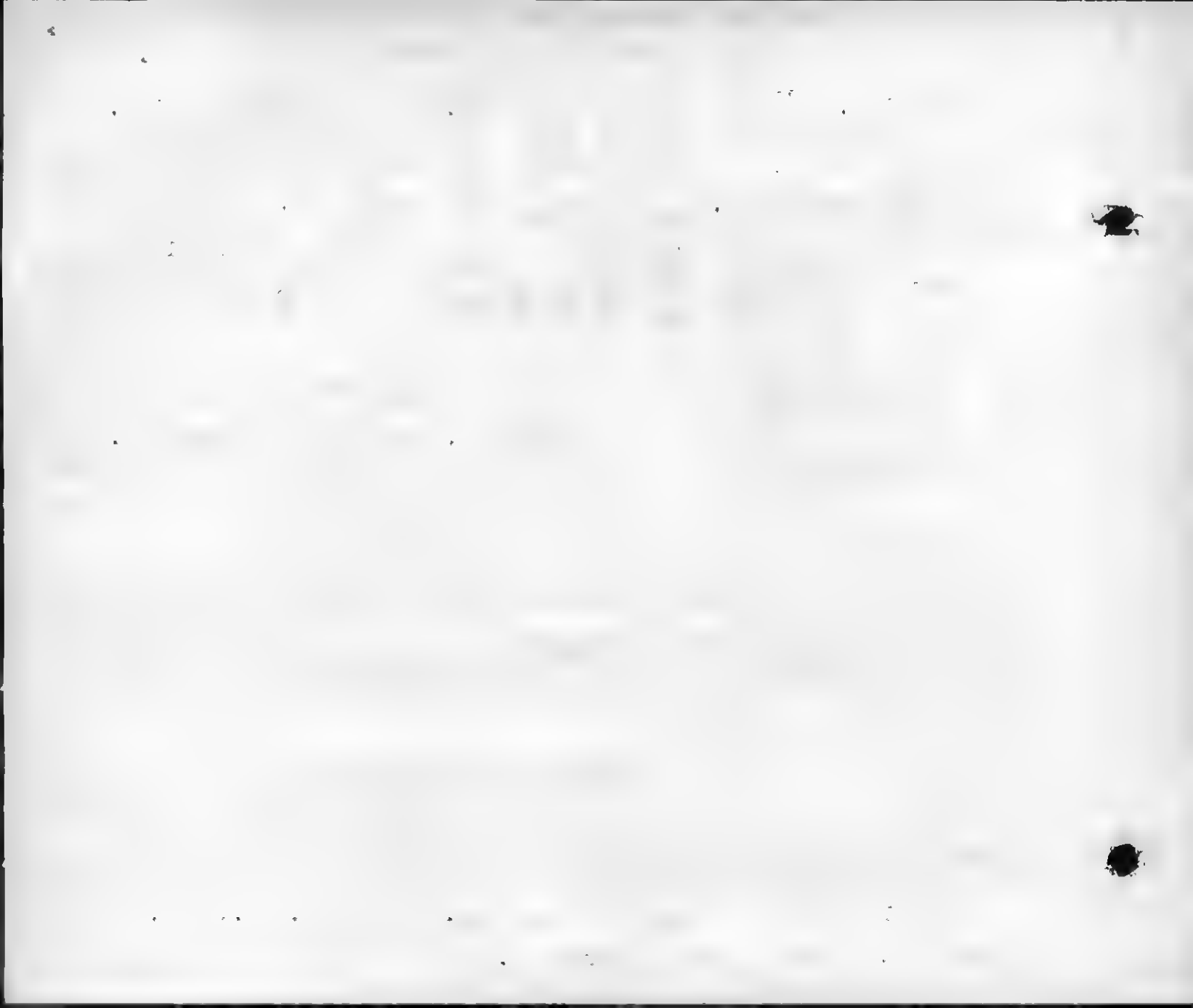
CERTIFICATE OF DEATH

06485

Reg. Dist. No.

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1319 Poplar Ave. | | d. STREET ADDRESS 1319 Poplar Ave. | |
| 3. NAME OF DECEASED (Type or print) First Bessie Middle Davis Last | | 4. DATE OF DEATH Month June Day 16 , Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-2-1889 |
| 9. AGE (In years last birthday) 69 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Waring | | 14. MOTHER'S MAIDEN NAME Mary Martin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Edward J. Davis | | Address 1319 Poplar Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO chronic hypertension (b) Myocardial infarction (c) Myocardial infarction | | INTERVAL BETWEEN ONSET AND DEATH? 1 1/2 hrs 1 1/2 hrs 5 1/2 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 16, 1958 to June 16, 1958 , that I last saw the deceased alive on June 16, 1958 , and that death occurred at 3:15 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE BB Brumbaugh | | DATE SIGNED 6/17/58 | |
| PHYSICIAN'S NAME (Type) BB Brumbaugh | | ADDRESS (Street, city or town, state) 516 09 Main St Baltimore Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-19-58 | 22c. NAME OF CEMETERY OR CREMATORY Measow Ridge Cem. | 22d. LOCATION (City, town, or county) (State) Balto. Co., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. | |
| 24a. REC'D BY REGISTRAR JUN 18 58 | | 24b. REGISTRAR'S SIGNATURE Arthur | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6508

CERTIFICATE OF DEATH

06486

Reg. Dist. No. 32

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 11 mo. | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side, Md 02 d. STREET ADDRESS Steamboat Pl. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Everett Dement | | 4. DATE OF DEATH Month Day Year 6 8 1958 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/24/1916 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Store | | 9b. KIND OF BUSINESS OR INDUSTRY Grocery | 9. AGE (In years last birthday) 67 yrs |
| 10. BIRTHPLACE (State or foreign country) Md | | 11. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 12. FATHER'S NAME James E. Dement | | 13. MOTHER'S MAIDEN NAME Sarah V. Jenkins | |
| 14. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes | | 15. SOCIAL SECURITY NO 577-05-1079 | |
| 16. INFORMANT Hospital Records, Mt. Wilson State Hospital | | 17. ADDRESS Hospital Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | 19. INTERVAL BETWEEN ONSET AND DEATH 3 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5/16 , 19 58 , to 6/8 , 19 58 , that I last saw the deceased alive on 6/8/58 (19 58), and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William Newcomer, M.D. Mt. Wilson, Maryland SUPERINTENDENT | | | |
| 22a. BURIAL, CREMATION, REINTERMENT (Specify) 6-12-58 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Forest Lincoln | | 22d. LOCATION (City, town, or county) (State) Calmar Manor Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Newcomer | | 24a. REC'D BY REGISTRAR JUN 11 '58 | |
| 24b. REGISTRAR'S SIGNATURE William Newcomer | | | |



6509

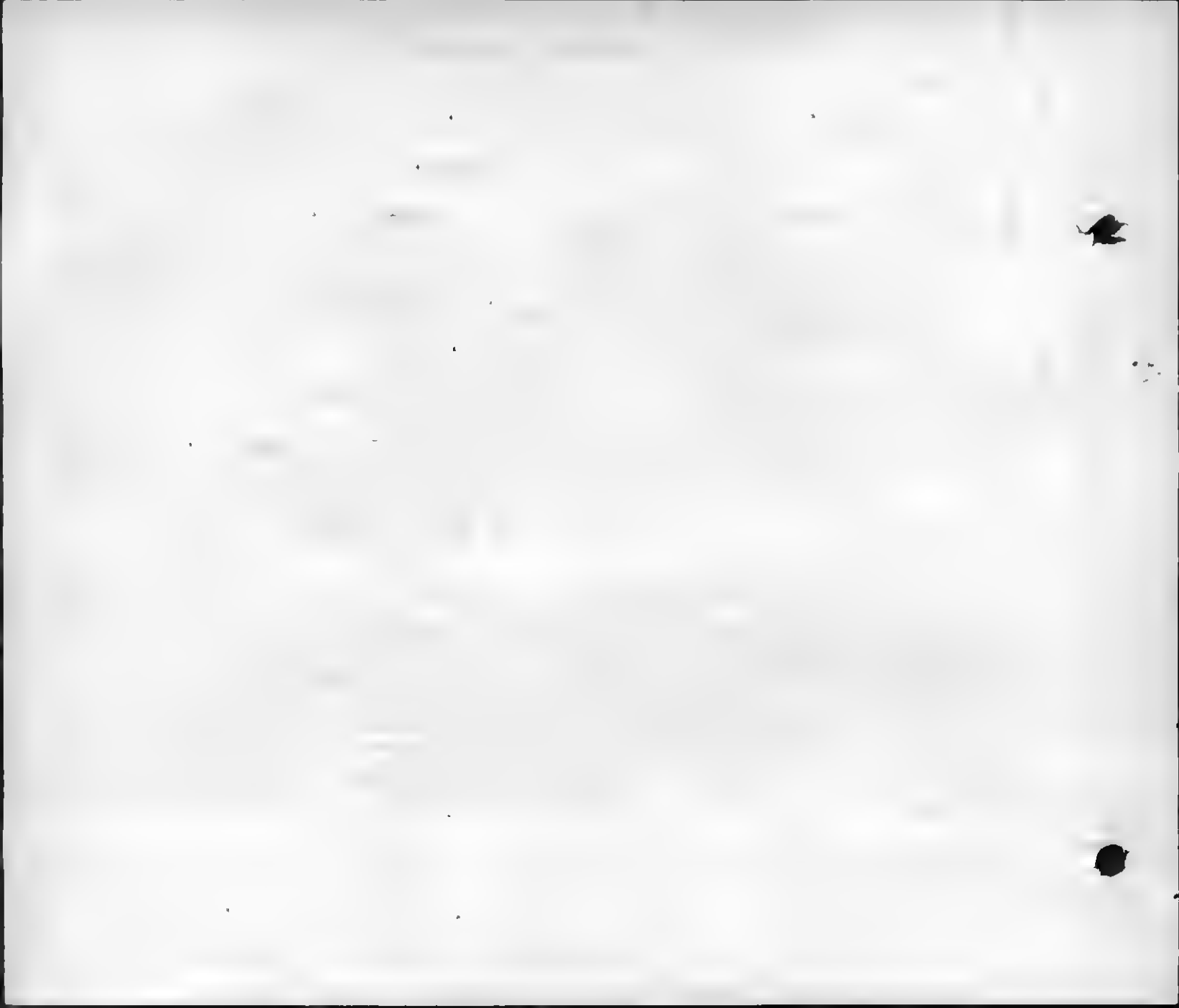
CERTIFICATE OF DEATH

Reg. Dist. 06487

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville | | | |
| d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Bidgeway Nursing Home | | | | d. STREET ADDRESS 401 Cralan Rd. | | | |
| 3. NAME OF DECEASED (Type or print) First SADIE Middle VIRGINIA Last DEMPSEY | | | | 4. DATE OF DEATH Month June Day 3 Year 1958 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 14, 1875 | | 9. AGE (In years last birthday) 82 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked | | 10b. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Austin Dempsey | | | | 14. MOTHER'S MAIDEN NAME Elexina Valentine | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Miss Edna Male - 401 Cralan Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho-Pneumonia DUE TO (c) Arterio-Sclerotic Heart Disease | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 6 days 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio-Sclerosis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 4, 1958 to June 3, 1958 that I last saw the deceased alive on June 2, 1958 and that death occurred at 11:00 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Earl L. Chambers | | | | DATE SIGNED 4108 Liberty Hts. Balt. Md. 6-4-58 | | | |
| PHYSICIAN'S NAME (Type) Earl L. Chambers | | | | ADDRESS 4108 Liberty Hts. Balt. Md. 6-4-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/6/58 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Wickner & Sons - Balt. | | | | 24a. REC'D BY REGISTRAR DATE JUN 5 '58 | | 24b. REGISTRAR'S SIGNATURE Wm. J. Wickner | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6466 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06488

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>58 Township Road</u> | | d. STREET ADDRESS <u>58 Township Road</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>George Fred Denny</u> | | 4. DATE OF DEATH Month Day Year <u>June 26, 1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 3, 1903</u> |
| 9. AGE (In years last birthday) <u>54</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boilermaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Hobough</u> | | 14. MOTHER'S MAIDEN NAME <u>Nellie Denny</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u> | | 16. SOCIAL SECURITY NO. <u>216-10-3189</u> | |
| 17. INFORMANT <u>Mrs. Alma Denny</u> | | Address <u>same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>M B Davis</u> | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/30/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Bradley</u> | | 24a. REC'D BY REGISTRAR <u>Dundalk 22 Maryland</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Al. J. Smith</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6510

CERTIFICATE OF DEATH

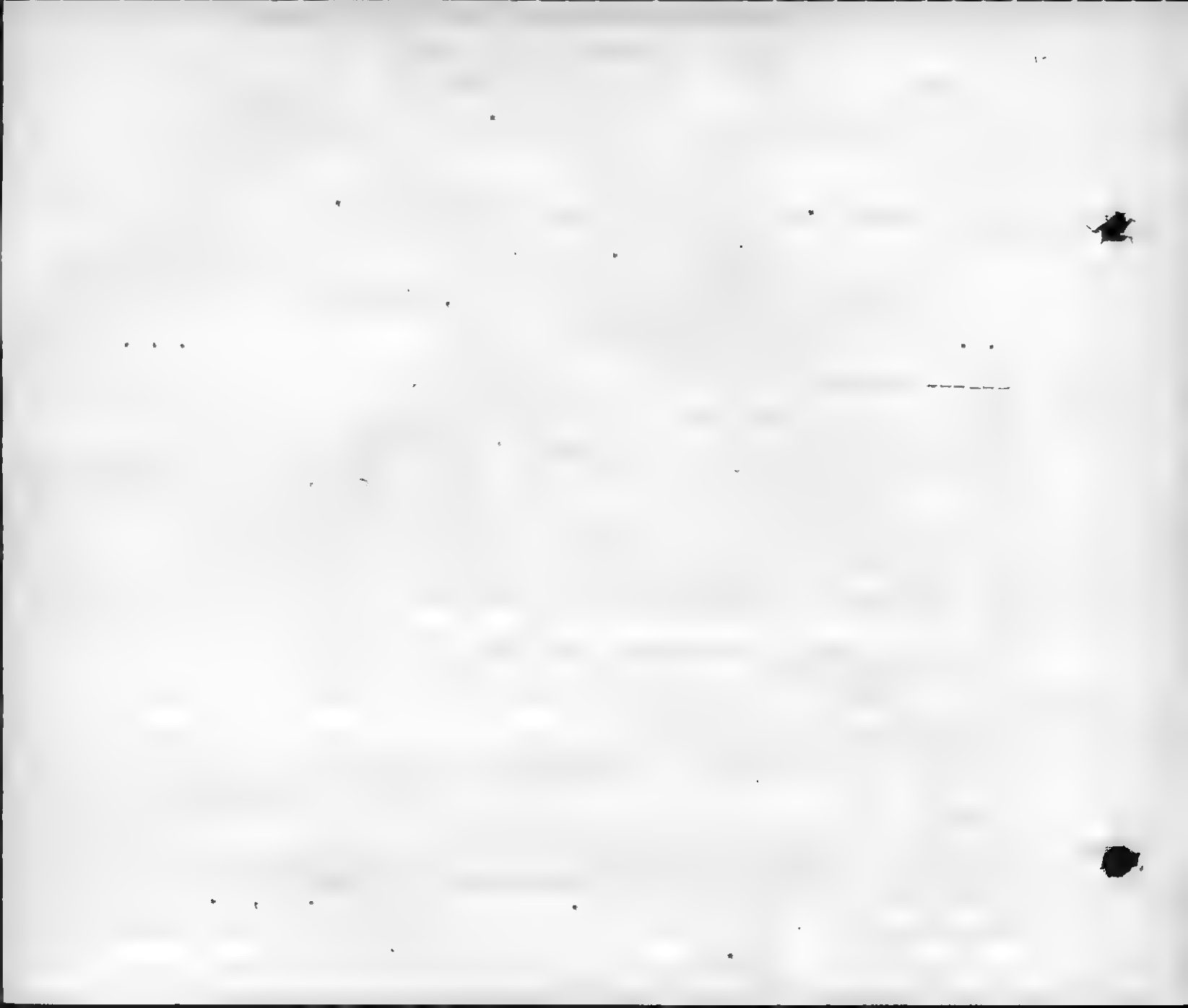
Reg. Dist. No.

06489

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 30 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 245 Gralan Rd. | | d. STREET ADDRESS 245 Gralan Rd. | |
| 3. NAME OF DECEASED (Type or print) First Jensine Middle B. Last Dow | | 4. DATE OF DEATH Month June Day 18 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 7, 1882 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR: Months 19 Days 19 Hours 19 Min. 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Norway | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Bortelsen | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Earl W. Dow (Son) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44xx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Quinricular Fibrillation Cardio-Vascular Renal Disease | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7.6 , 19 58 , to 6.18 , 19 58 , that I last saw the deceased alive on 6.18 , 19 58 , and that death occurred at 3 P. M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE George E. Urban | | M.D. 805 Frederick Ave 28 Md DATE SIGNED 6.19.58 | |
| PHYSICIAN'S NAME (Type) George E. URBAN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 21/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Pk. | | 22d. LOCATION (City, town, or county) (State) Balto. 29, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE 4101 Edmondson Ave. | | 24a. REC'D BY REGISTRAR DATE JUN 20 '58 | |
| 24b. REGISTRAR'S SIGNATURE Overman | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6511

CERTIFICATE OF DEATH

Reg. Dist. No.

06490

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX | | | |
| c. LENGTH OF STAY IN 1b 16 YEARS | | | | d. STREET ADDRESS 28 STEMMERS RUN ROAD | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 STEMMERS RUN ROAD | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH PAULINE DORR | | | | 4. DATE OF DEATH Month Day Year JUNE 14 1958 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JULY 26, 1875 | |
| 9. AGE (In years last birthday) 82 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PAPPADITIS SWEENEY | | | | 14. MOTHER'S MAIDEN NAME ELIZABETH PERKINS JONES | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO (If yes, give year or dates of service) NONE | | 17. INFORMANT Address EDWARD DORR SAME AS #2 | | | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA, 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-14 , 19 58 , to 6-14 , 19 58 , that I last saw the deceased alive on 12:15 AM , 19 58 , and that death occurred at 6-15 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE John F. Cissner M.D. 701 EASTERN AVE. - ESSEX 6/16/58 PHYSICIAN'S NAME (Type) JOHN F. CISSNER, M.D. 701 EASTERN AVE. - ESSEX | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/18/58 | | 22c. NAME OF CEMETERY OR CREMATORY MORELAND MSN. | | 22d. LOCATION (City, town, or county) (State) BALTIMORE MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur R. Smith, Jr., Inc., No. 400, N. W. | | | | 24a. REC'D BY REGISTRAR JUN 16 58 | | 24b. REGISTRAR'S SIGNATURE W. J. ... | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, by the funeral director, or by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6512

CERTIFICATE OF DEATH

66491

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Pikesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u> | | d. STREET ADDRESS <u>7309 Prince Georges Road</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Jeffery</u> Middle <u>Young</u> Last <u>Dubel</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 23, 1958</u> |
| 9. AGE (In years lost birthday) yrs <u>16</u> Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min <u>16</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Dubel</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Miles</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Robert Dubel</u> | | Address <u>Pikesville 8, Md.</u> <u>7309 Prince Georges Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease</u> (c) <u>probably Transition in Blood Vessels</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| INTERVAL BETWEEN ONSET OF DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 23, 1958</u> to <u>June 5, 1958</u> , that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Irving Kramer</u> M.D. | | DATE SIGNED <u>June 11, 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>Irving Kramer M.D.</u> | | ADDRESS <u>700 Reisterstown Rd. Pikesville 8, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 9, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Quaker Burying Ground</u> | | 22d. LOCATION (City, town, or county) (State) <u>Galesville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell Pikesville</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6513

CERTIFICATE OF DEATH

06492

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 2 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. STREET ADDRESS 4126 PARKSIDE DR. | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LEO Middle R. Last DUNN | | 4. DATE OF DEATH Month June Day 15 Year 1958 | | 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 17, 1895 | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Factory | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James E. Dunn | | | | 14. MOTHER'S MAIDEN NAME Mary McCarron | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW I | | 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) UNKNOWN CAUSE DUE TO (c) CEREBRAL VASCULAR ACCIDENT | | | | | | INTERVAL BETWEEN ONSET AND DEATH 17 hrs. 2 days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 13, 1958 to June 15, 1958 and that death occurred at 5:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 6/15/58 | | | | | | | |
| ACTUAL SIGNATURE <i>E. Hunter Wilson</i> | | M.D. VAH, FORT HOWARD, MARYLAND | | | | | |
| PHYSICIAN'S NAME (Type) E. HUNTER WILSON, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF JUNE 18-58 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Dippel Brothers, 7110 Belair Rd., Balto. 6, Md. | | | | 24a. REC'D BY REGISTRAR JUN 17 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Overman</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6514

CERTIFICATE OF DEATH

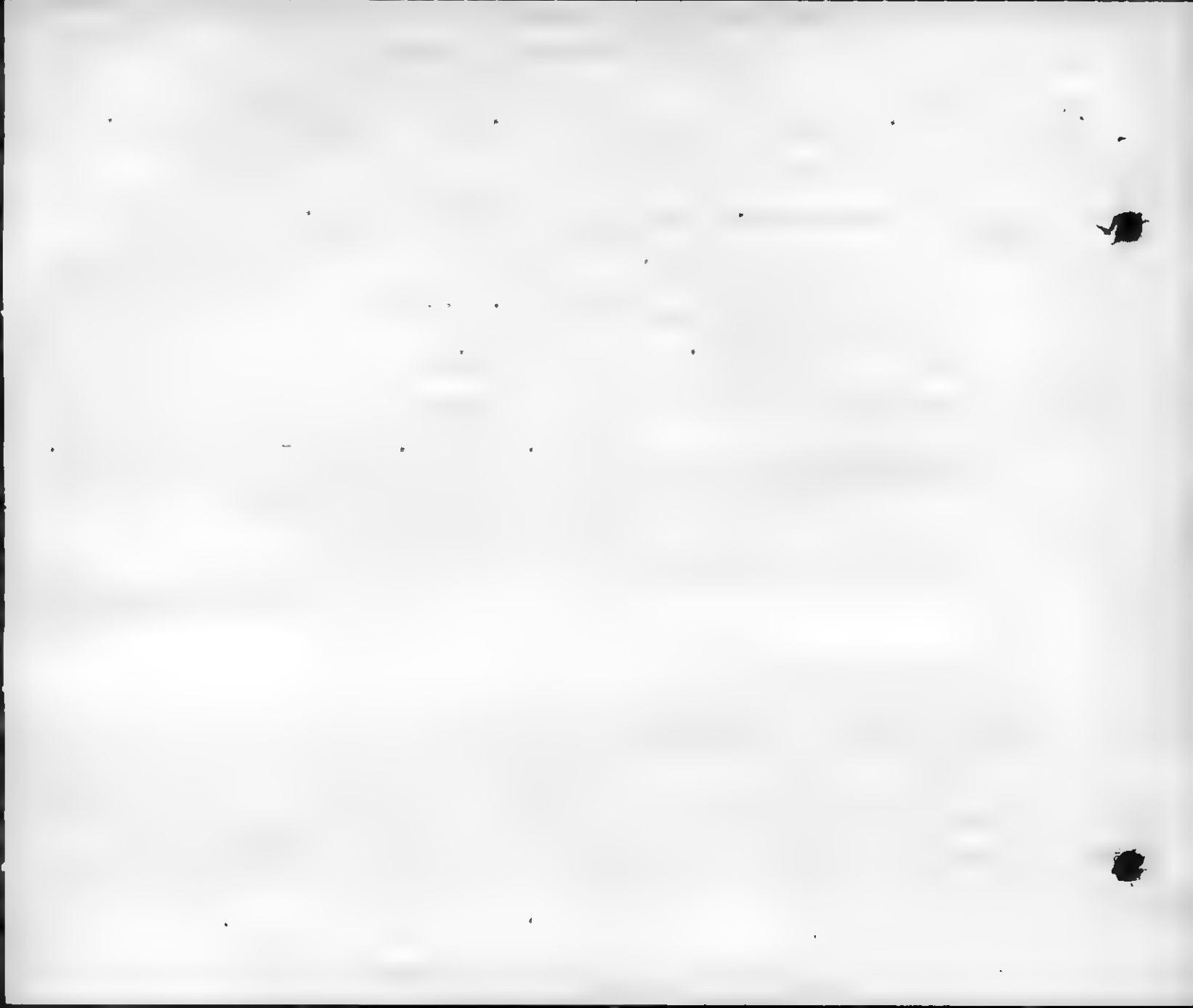
06493

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zone #7 | | | | c. LENGTH OF STAY IN 1b Zone #7 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Ingleside Ave. | | | | d. STREET ADDRESS 1200 Ingleside Ave. | | | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle J. Last DUNNOCK | | | | 4. DATE OF DEATH Month June Day 30 Year 1958 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 28, 1884 | | 9. AGE (In years last birthday) 74 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (rtd) self emp. | | | 10b. KIND OF BUSINESS OR INDUSTRY emp. | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address Mr. Charles W. Dunnock - 1200 Ingleside Ave. 7 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 11, 1948 to June 30, 1958 , that I last saw the deceased alive on June 28, 1958 , and that death occurred at 5 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 4111 Liberty Heights Rd. Balt., Md. | | | | | | | |
| ACTUAL SIGNATURE Albert Shochat | | M. D. 4111 Liberty Heights Rd. Balt., Md. | | | | | |
| PRINTED NAME (Type) Albert H. Shochat M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/3/58 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem. | | 22d. LOCATION (City, town, or county) (State) Woodlawn, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Vickner & Sons - Balt 172 | | | | 24a. REC'D BY REGISTRAR DATE JUL 2 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6467

CERTIFICATE OF DEATH

Reg. Dist. No.

06494

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE MD b. COUNTY BALTO. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK | | | |
| c. LENGTH OF STAY IN 1b 12 YRS | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3202 MCSHANEWAY | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JACOB EUGENE EAGLE | | | | 4. DATE OF DEATH 6/29/58 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH SEPT. 20, 1898 | |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months — Days — Hours — Min. — | | 11. BIRTHPLACE (State or foreign country) N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER | | | | 10b. KIND OF BUSINESS OR INDUSTRY CERAMIC | | | |
| 13. FATHER'S NAME JACOB EAGLE | | | | 14. MOTHER'S MAIDEN NAME MARY MC DONALD | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 167-10-84 | | 17. INFORMANT JUNIA O'BRIEN EAGLE Address — SAME | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lungs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Carcinoma due to metastasis DUE TO (c) — | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3-21 , 19 58 , to 6-29 , 19 58 , that I last saw the deceased alive on 6-29 , 19 58 , and that death occurred at 11:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 MORNINGTON RD. BALTO. MD DATE SIGNED 6/30/58 | | | | | | | |
| ACTUAL SIGNATURE Eugene F Newy M.D. 7001 MORNINGTON RD. BALTO. MD | | | | | | | |
| PHYSICIAN'S NAME (Type) EUGENE NEWY, M.D. 7001 MORNINGTON - DUNDALK, MD | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 7/2/58 | | 22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL | | 22d. LOCATION (City, town, or county) (State) BALTO. MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Burke Bradley, Dundalk, Md | | | | 24a. REC'D BY REGISTRAR DATE JUL 2 '58 | | 24b. REGISTRAR'S SIGNATURE — | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6515

CERTIFICATE OF DEATH

Reg. Dist. No.

06495

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | c. LENGTH OF STAY IN 1b <u>7 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>115 Slade Ave</u> | | | | d. STREET ADDRESS <u>115 Slade Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF <u>MARTHA JANE EATON</u> (Type or print) First Middle Last | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 10, 1874</u> | 9. AGE (In years last birthday) <u>83</u> yrs. | IF UNDER 1 YEAR: Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min. | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joshua Stuller</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Deborah Cornell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO <u>none</u> | | 17. INFORMANT <u>Joshua Eaton, 7020 Alden Rd, Pikesville</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4x10.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>few years</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>01</u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1955 to 3 June 1958</u> , that I last saw the deceased alive on <u>24 May 1958</u> , and that death occurred at <u>330 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Paul H. Royse</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>808 Rustertown Rd, Pikesville 8 Md</u> | | | |
| DATE SIGNED <u>3 June 58</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>PAUL H. ROYSE MD</u> <u>Pikesville 8 Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-6-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u> | | 22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8 Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

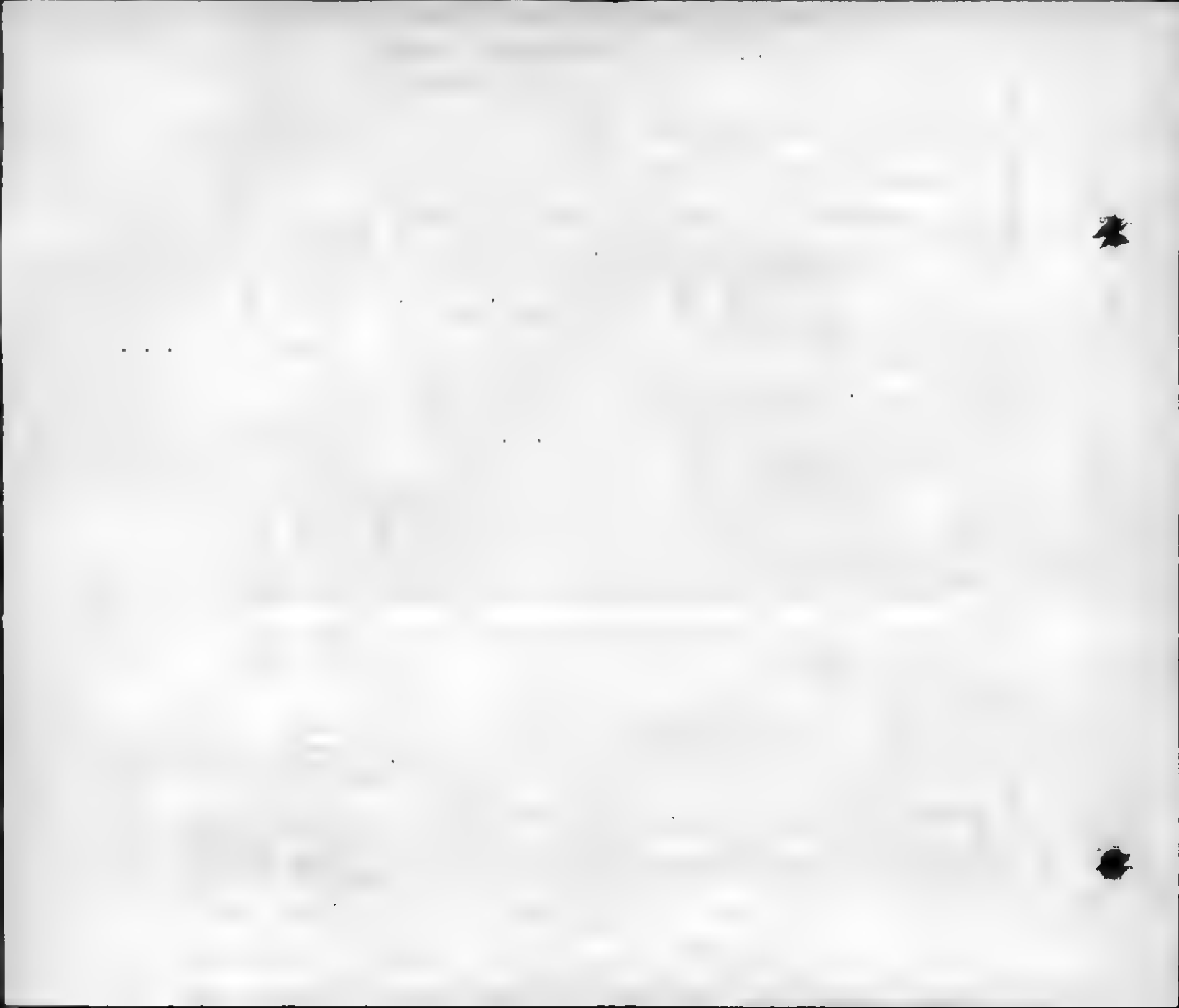
6516

CERTIFICATE OF DEATH

06496

Reg. Dist. No.

| | | | | | | | |
|---|--|--|---------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Catonsville | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5415 Old Frederick Road | | | | d. STREET ADDRESS 5415 Old Frederick Road #29 | | | |
| 3. NAME OF DECEASED (Type or print) First KATHERINE Middle C. Last EITEMILLER | | | | 4. DATE OF DEATH Month June Day 16 Year 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 23, 1878 | 9. AGE (In years last birthday) 79 yrs. | IF UNDER 1 YEAR Months 79 Days 16 Hours 19 Min. | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Christian G. Gruetzer | | | | 14. MOTHER'S MAIDEN NAME Henrietta Linck | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Address Mr. C. Albert Eitemiller-7337 Windsor Mill Road | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH years | | | | | | 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Hour 19 o. m. p. m. Month, Day, Year | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 5, 1950 to June 16, 1958 that I last saw the deceased alive on June 16, 1958 and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 651 N. Beutalou Baltimore 16 Md. DATE SIGNED 6/16/58 | | | | | | | |
| ACTUAL SIGNATURE C. S. Mandelis | | PHYSICIAN'S NAME (Type) C. S. Mandelis | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/19/58 | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 22d. LOCATION (City, town or county) (State) Woodlawn, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckner ADDRESS Balto - 17 Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 17 1958 | | 24b. REGISTRAR'S SIGNATURE Carl Smith | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6517

CERTIFICATE OF DEATH

06497

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u> | | | | c. LENGTH OF STAY IN 1b <u>Life</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3522 Wild Cherry Road.</u> | | | | d. STREET ADDRESS <u>3522 Wild Cherry Road (Balto 7)</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Warren</u> Last <u>Emmart</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1958</u> | | | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED | | 8. DATE OF BIRTH <u>March 19, 1874</u> | |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY (Retired) <u>Farmer Owner</u> | | 11. BIRTHPLACE (State or foreign country) <u>Rockdale</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>William H. Emmart</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura V. Timanus</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Mrs. Elizabeth M. Emmart 3522 Wild Cherry Road</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA, RECTUM - C</u> DUE TO (b) <u>METASTASIS TO LIVER =</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>APRIL 1, 1954</u> to <u>JUNE 16, 1958</u> , that I last saw the deceased alive on <u>JUNE 16, 1958</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D. <u>3601 Chynar Rd</u> | | | | ADDRESS (Street, city or town, state) <u>BALTO -</u> | | | |
| PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u> | | | | DATE SIGNED <u>6/17/58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 18, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Erving Byers</u> ADDRESS <u>8728 Liberty Road, Randallstown, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 23 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6518

CERTIFICATE OF DEATH

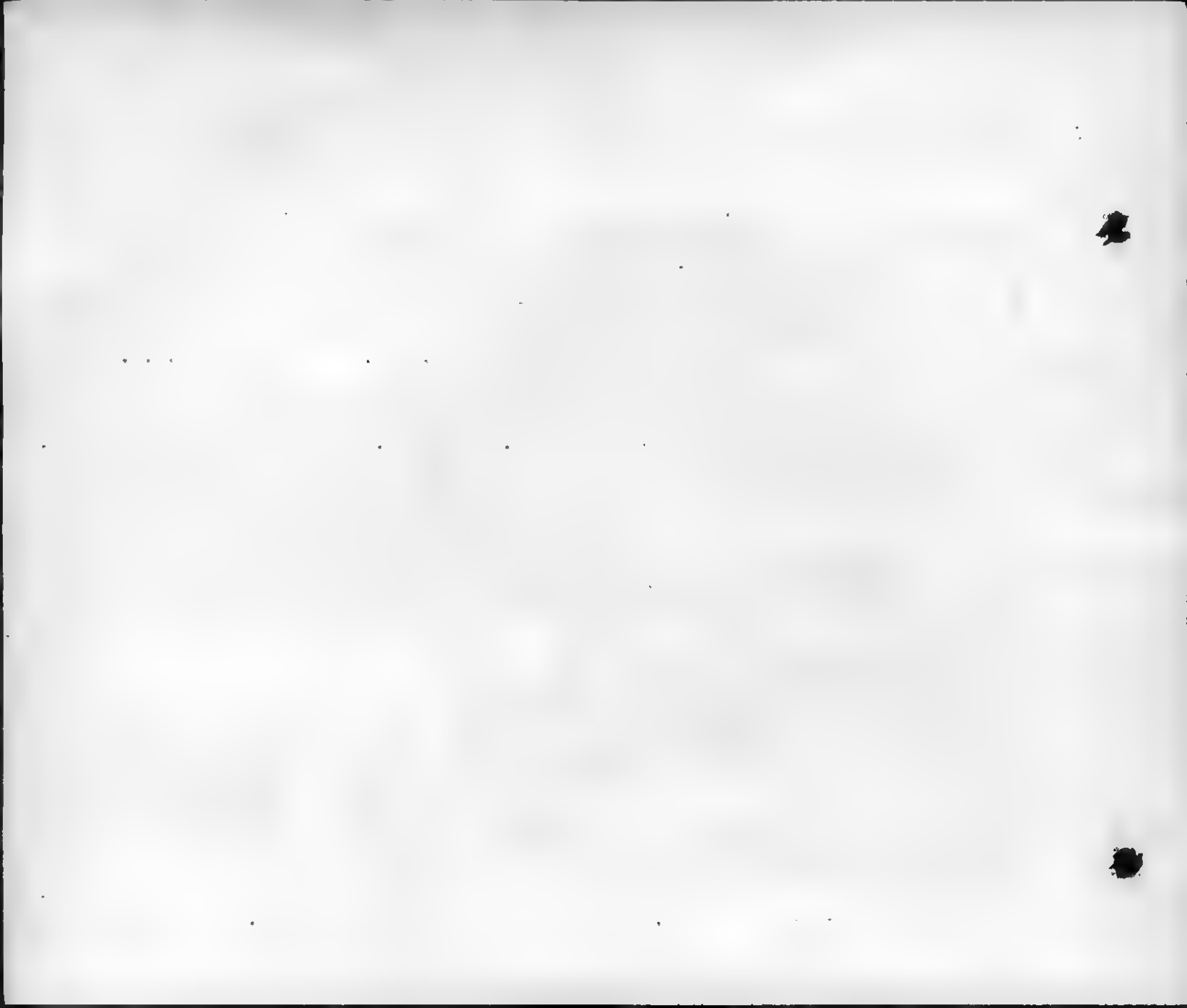
Reg. Dist. No.

06498

| | | | |
|--|----------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Bird River</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 244 Ebenezer Rd.</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 57</u> | |
| f. STREET ADDRESS <u>Box 244 Ebenezer Rd.</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph A. Eurice</u> | | 4. DATE OF DEATH Month Day Year <u>June 21 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-4-1897</u> |
| 9. AGE (In years last birthday) yrs. <u>61</u> | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto., Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Joseph Eurice</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Winkler</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u> | | 16. SOCIAL SECURITY NO <u>217-1b-9964</u> | |
| 17. INFORMANT <u>Mrs. Theresa E. Eurice</u> | | Address <u>Box 244 Ebenezer Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestatic Cancer</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Carcinoma of Cecum</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 weeks</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5402 Belair Rd.</u> |
| 20f. (City or town) <u>Baltimore</u> | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>4-18</u> , 19 <u>58</u> , to <u>6-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>58</u> , and that death occurred at <u>10:30 P. M.</u> from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE <u>Michael J. Grossfeld</u> M.D. PHYSICIAN'S NAME (Type) <u>Michael J. Grossfeld MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-25-1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Horne Inc. 7401 Belair Rd.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Dee Leach</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-box papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6519

Item 7 1958-12-58 et

CERTIFICATE OF DEATH

06499

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|--|--------------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Monkton</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton Rural</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>J.M. Pearce Road</u> | | | | e. STREET ADDRESS <u>J.M. Pearce Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Williams</u> Middle <u>M</u> Last <u>Evans</u> | | | | 4. DATE OF DEATH <u>June</u> Month <u>4</u> Day <u>1958</u> Year | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10 Oct -1882</u> | 9. AGE (In years last birthday) <u>75</u> yrs. | IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>58</u> Min | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Evans Air Products</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Gases</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>George W Evans</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Ann Corran</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) | | | |
| 16. SOCIAL SECURITY NO. <u>068-26-9976</u> | | | | 17. INFORMANT <u>Sister M. Lane</u> Address <u>Monkton Md - Same</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>0. 58</u> p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | | 20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | | | |
| 21. I certify that I attended the deceased from <u>1956</u> to <u>June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>58</u> , and that death occurred at <u>4:4</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Cockeysville</u> DATE SIGNED <u>9 June 1958</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u> | | | | Nurse <u>Mary Carol</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-12-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St. James Episcopal</u> | | 22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Scott Brooks</u> ADDRESS <u>622 York Rd., Towson 4, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>Jun 13 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6520

CERTIFICATE OF DEATH

06500

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|---------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Woodlawn | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6437 Kriel Street | | | | e. STREET ADDRESS 6437 Kriel Street | | | |
| 3. NAME OF DECEASED (Type or print) Dominic Fava | | | | 4. DATE OF DEATH Month June Day 10 Year 19 58 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/13/1888 | | 9. AGE (In years last birthday) 69 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Fava Prod. | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph Fava | | | | 14. MOTHER'S MAIDEN NAME Johanna M. Garbo | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO | | 16. SOCIAL SECURITY NO. 214.03.1991 | | 17. INFORMANT Address Mrs. Sarah Fava 6437 Kriel St. (7) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan , 19 57 , to June , 19 58 , that I last saw the deceased alive on June 10 , 19 58 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4509 Liberty Heights Ave DATE SIGNED 6-11-58 | | | | | | | |
| ACTUAL SIGNATURE Dr. Thos J. Libbott | | M.D. 4509 Liberty Heights Ave | | PHYSICIAN'S NAME (Type) Dr. Thos J. Libbott | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/13/58 | | 22c. NAME OF CEMETERY OR CREMATORY Lorraine | | 22d. LOCATION (City, town, or county) (State) Woodlawn Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. T. Stansbury | | | | ADDRESS 6411 Windsor Mill Rd. 7 | | 24a. REC'D BY REGISTRAR DATE JUN 12 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. Seach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6521

CERTIFICATE OF DEATH

Reg. Dist. No. 06501

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1500 Carrollton Avenue | | d. STREET ADDRESS 1500 Carrollton Avenue | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARTHA ELIZABETH FISHPAW | | 4. DATE OF DEATH Month Day Year June 2, 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21, 1861 |
| 9. AGE (In years last birthday) 97 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Henry Leaf | | 14. MOTHER'S MAIDEN NAME Mary Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. H.W. Shipley, Ruxton, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism 1500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction (c) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1, 1958 to June 2, 1958 that I last saw the deceased alive on June 1, 1958 and that death occurred at 6:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE George J. Gilman, M.D. | | DATE SIGNED June 4, 1958 | |
| PHYSICIAN'S NAME (Type) G. F. GILMAN, M.D. | | L. V. H. F. ILLI, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 4, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Jessops Cemetery | 22d. LOCATION (City, town, or county) (State) Cockeysville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland | | 24a. REC'D BY REGISTRAR DATE | |
| | | 24b. REGISTRAR'S SIGNATURE W. B. Smith | |

1. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



6478

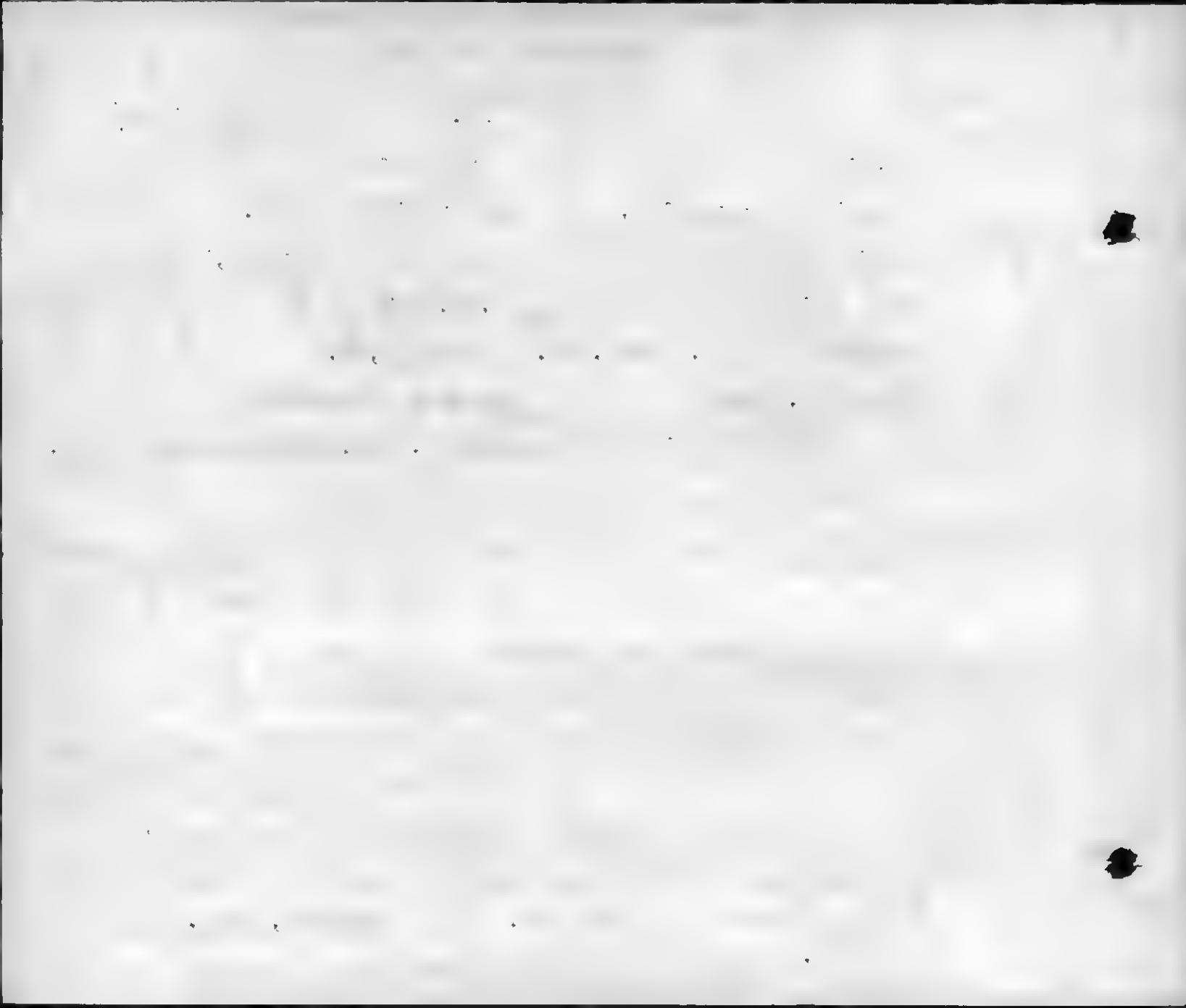
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4209 Washington Blvd. | | e. d. STREET ADDRESS 4209 Washington Blvd. | |
| 3. NAME OF DECEASED (Type or print) Cecil Warren Feor First Middle Last | | 4. DATE OF DEATH June 8, 1958 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 24, 1907 |
| 9. AGE (In years last birthday) 51 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Am. Const. Co. | |
| 11. BIRTHPLACE (State or foreign country) Everette, Pa. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Charles G. Feor | | 14. MOTHER'S MAIDEN NAME Margaret Householder | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none | | 16. SOCIAL SECURITY NO. 173-14-4768 | |
| 17. INFORMANT LaDonna G. Feor | | Address 4209 Washington Blvd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 6 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Stomach + Liver | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 1952 to June 8, 1958 , that I last saw the deceased alive on June 6, 1958 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1264 Francis Ave DATE SIGNED 6-8-58 | | | |
| ACTUAL SIGNATURE A. Bradley Laugherty M.D. | | PHYSICIAN'S NAME (Type) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/12/58 | 22c. NAME OF CEMETERY OR CREMATORY Everette Pa. | 22d. LOCATION (City, town, or county) (State) Everett, Penn. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | 24a. REC'D BY REGISTRAR DATE JUN 10 '58 | 24b. REGISTRAR'S SIGNATURE W. J. Leach |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06503

6468

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|---|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTC.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTC.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> | | c. LENGTH OF STAY IN 1b <u>15 YRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1919 GREENSWAY</u> | | | | d. STREET ADDRESS <u>1919 GREENSWAY</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JOHN LEROY FRENCH, JR.</u> | | | | 4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1958</u> | | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 1, 1896</u> | 9. AGE (In years last birthday) <u>67</u> yrs | 10. UNDER 1 YEAR Months <u>6</u> Days <u>14</u> | 11. IF UNDER 24 HRS Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAB. TECH.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CHEMICAL MFG.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>JOHN H. FRENCH, SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>EMMA BRIGHI FRENCH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>216-01-5674</u> | | 17. INFORMANT <u>MRS. JOHN J. FEEBEEK - SHINE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>AS-C-V-DISEASE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | 20g. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>M. B. Davis</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/17/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>BALTC. NATIONAL</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Feebreek, Haverhill, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>John J. Feebreek</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6479

CERTIFICATE OF DEATH

Reg. Dist. No.

06504

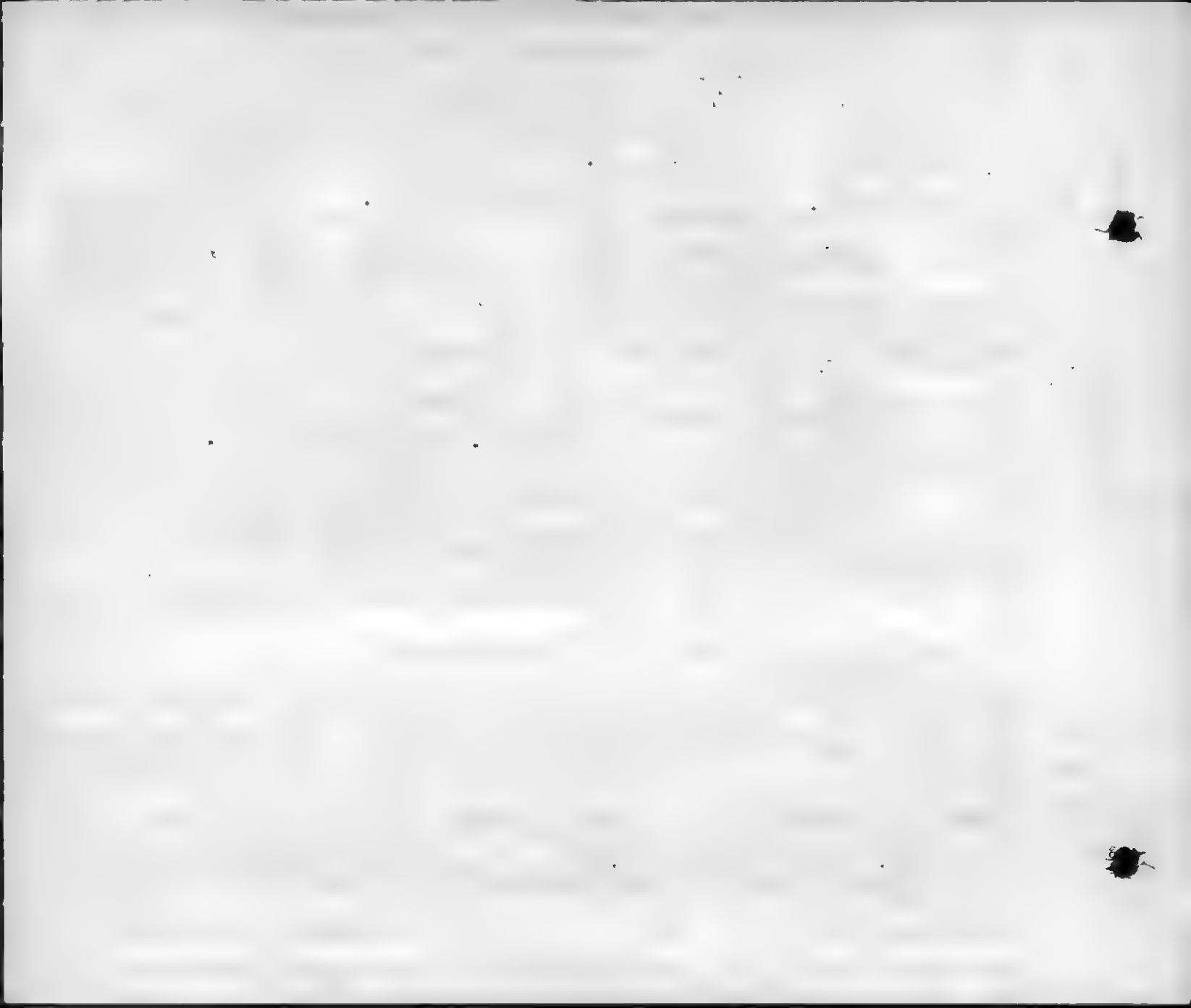
| | | | | | | | |
|--|--|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | | c. LENGTH OF STAY IN 1b 31 yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1248 Elm Rd. | | | | d. STREET ADDRESS 1248 Elm Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mamie Elizabeth Fritz | | | | 4. DATE OF DEATH Month Day Year June 7, 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2/17/95 | |
| 9. AGE (In years last birthday) yrs. 63 | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | 12. CITIZEN OF WHAT COUNTRY? | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Chester Heck | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address John W. Fritz 1248 Elm Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Heart Disease and DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that I attended the deceased from Aug 1, 1952 to June 7, 1958 that I last saw the deceased olive on June 1, 1957 and that death occurred at 5:45 PM from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE A. Bradley Dougherty, M.D. | | | | ADDRESS (Street, city or town, state) 1264 Francis Ave. Balt 27 DATE SIGNED 6-8-58 | | | |
| PHYSICIAN'S NAME (Type) A. Bradley Dougherty, M.D. | | | | 1264 Francis Ave., Baltimore 27, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-10-58 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph Ambrose Jr. 1328 Sulphur Spring Rd. Baltimore 27, Md. | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 10 1958



6522

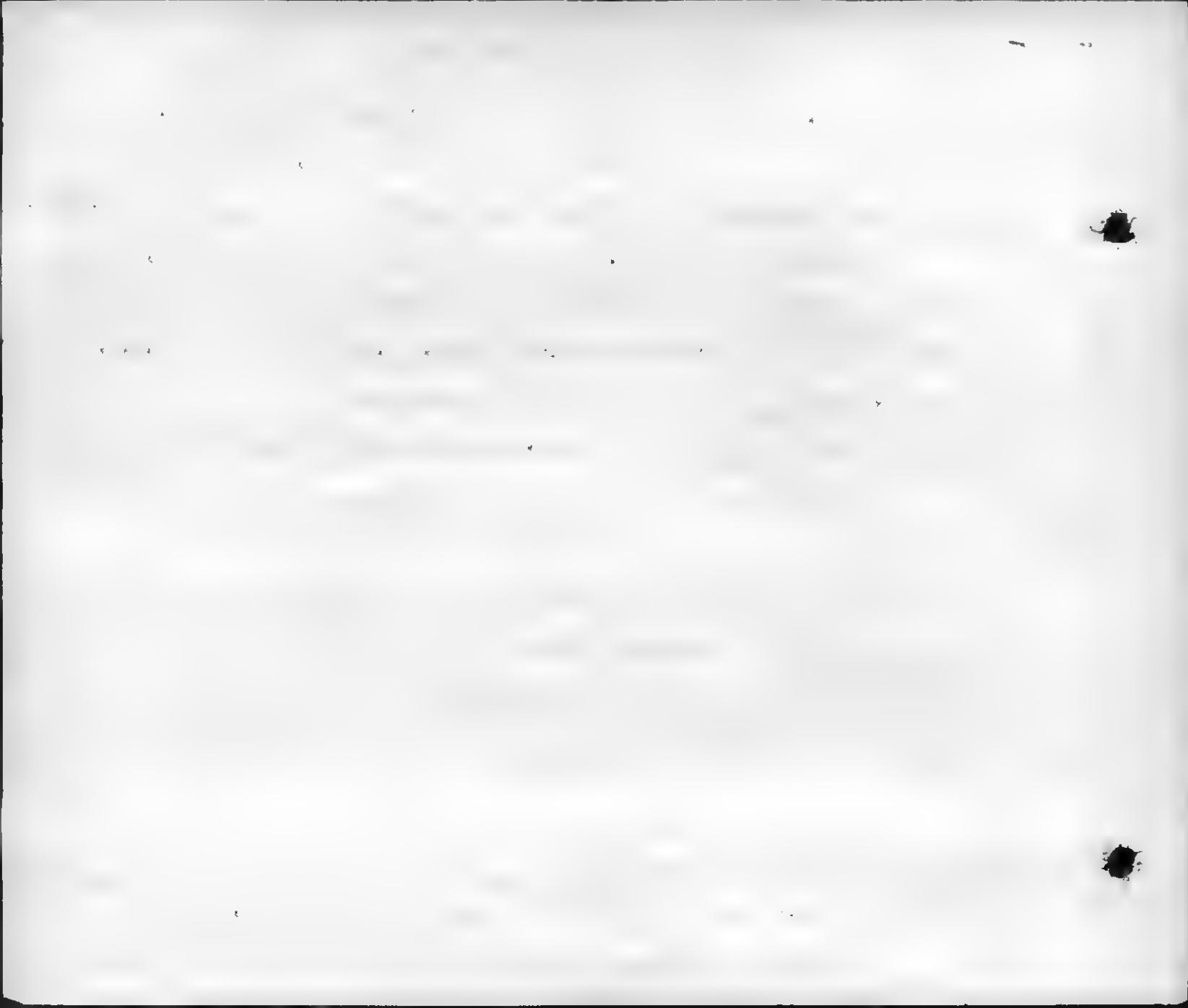
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale, Balto 7, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Forrest Haven Nursing Home | | d. STREET ADDRESS 3632 Marriott Lane | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Carrie Middle B. Last Fryfogel | | 4. DATE OF DEATH Month June Day 29th Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARITAL STATUS WIDOWED | 8. DATE OF BIRTH April 15, 1866 |
| 9. AGE (In years last birthday) 92 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Practical Nursing | |
| 11. BIRTHPLACE (State or foreign country) Balto. Co. Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert N. Waller | | 14. MOTHER'S MAIDEN NAME Jane Tase | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Olive Barnett | | Address 3632 Marriott Lane Zone 7 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO PER MURDER & DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CHANGES DUE TO VASCULAR DISEASE (c) VASCULAR DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/29 , 1958 to 6/29 , 1958 that I last saw the deceased alive on 6/29 , 1958, and that death occurred at 2:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5800 E. 4th Ave. BALTO. MD. DATE SIGNED John H. Shaw | | | |
| ACTUAL SIGNATURE John H. Shaw M.D. 5800 E. 4th Ave. BALTO. MD. | | | |
| PHYSICIAN'S NAME (Type) John H. Shaw MD DR. J. H. SHAW | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 2, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery | 22d. LOCATION (City, town, or county) (State) Randallstown, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Spring Byers | | ADDRESS 8728 Liberty Road, Randallstown | |
| 24a. REC'D BY REGISTRAR DATE JUL 8 '58 | | 24b. REGISTRAR'S SIGNATURE W. L. Leach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 32

6523

| | | | |
|---|--|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | d. STREET ADDRESS 109 ALDERSHOT ROAD | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CHARLES FRANKLIN GALLION | | 4. DATE OF DEATH Month Day Year G 22 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-19-04 |
| 9. AGE (In years last birthday) yrs. 54 | | 10. IF UNDER 1 YEAR Months Days Hours Min 54 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELEVATOR OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY ELEVATOR OPERATOR HOTEL | |
| 11. BIRTHPLACE (State or foreign country) STATE | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME JOSEPH GALLION | | 14. MOTHER'S MAIDEN NAME JENNIE SALE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO 212 09 8545 | |
| 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 7-25-1956 , to 6-12-1958 , that I last saw the deceased alive on 6-22-1958 , and that death occurred at 12:10 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED 6-22-58 | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | PHYSICIAN'S NAME (Type) William Newcomer, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 25/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 22d. LOCATION (City, town, or county) (State) Baltimore 29, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witzke, JR. | | 24a. REC'D BY REGISTRAR Edmondson | |
| 24b. REGISTRAR'S SIGNATURE W. A. Witzke | | DATE 24 58 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|---|--------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point | | | | c. LENGTH OF STAY IN lb 26 YRS. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Dispensary | | | | e. STREET ADDRESS 911 "F" Street | | | |
| 3. NAME OF DECEASED (Type or print) First John Middle RUFF Last GIBSON, SR | | | | 4. DATE OF DEATH Month 6 Day 23 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 16, 1906 | 9. AGE (In years last birthday) 51 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Steel | | 11. BIRTHPLACE (State or foreign country) md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH GIBSON | | | | 14. MOTHER'S MAIDEN NAME LYLA HENRY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 713-07-2175 | | 17. INFORMANT EVELYN R. GIBSON, SR. | | Address SAME | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive C-V Disease (a), stating the underlying cause last. DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE M. B. Davis | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Melvin B. Davis, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/24/58 | | 22c. NAME OF CEMETERY OR CREMATORY OLAK LAWN | | 22d. LOCATION (City, town, or county) (State) BALTO. CO., md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Bunker Bradley, Jr., Baltimore, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 26 '58 | | 24. REGISTRAR'S SIGNATURE W. B. Beach | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6525

CERTIFICATE OF DEATH

Reg. Dist. No.

06508

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 22 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle (MAY) Last GONSHOR | | 4. DATE OF DEATH Month JUNE Day 1 Year 19 58 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 29 1888 |
| 9. AGE (In years last birthday) 70 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY STEEL MILL | |
| 11. BIRTHPLACE (State or foreign country) WARSAW POLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH GONSHOR | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 213-27-5333 | |
| 17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LARYNX WITH EXTENSIVE METASTASIS TO THE NECK ORGANS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY 10 , 19 58 , to JUNE 1 , 19 58 , and that death occurred at 4:10 a.m., from the causes and on the date stated above ADDRESS (Street, city or town, state) VAH FORT HOWARD MARYLAND DATE SIGNED 6-1-58 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH FORT HOWARD MARYLAND 6-1-58 PHYSICIAN'S NAME (Type) CHIEN WEI LAN M.D. VAH FORT HOWARD MARYLAND 6-1-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/4/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF MARY | | 22d. LOCATION (City, town, or county) (State) BALTIMORE 22 MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Dundalk 22, Md | | 24a. REC'D BY REGISTRAR DATE JUN 4 1958 | |
| 24b. REGISTRAR'S SIGNATURE Walter Brooks Bradley | | | |

WALTER BROOKS BRADLEY INC 700 WILLOW SPRING RD BALTIMORE 22 MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6526

CERTIFICATE OF DEATH

06509

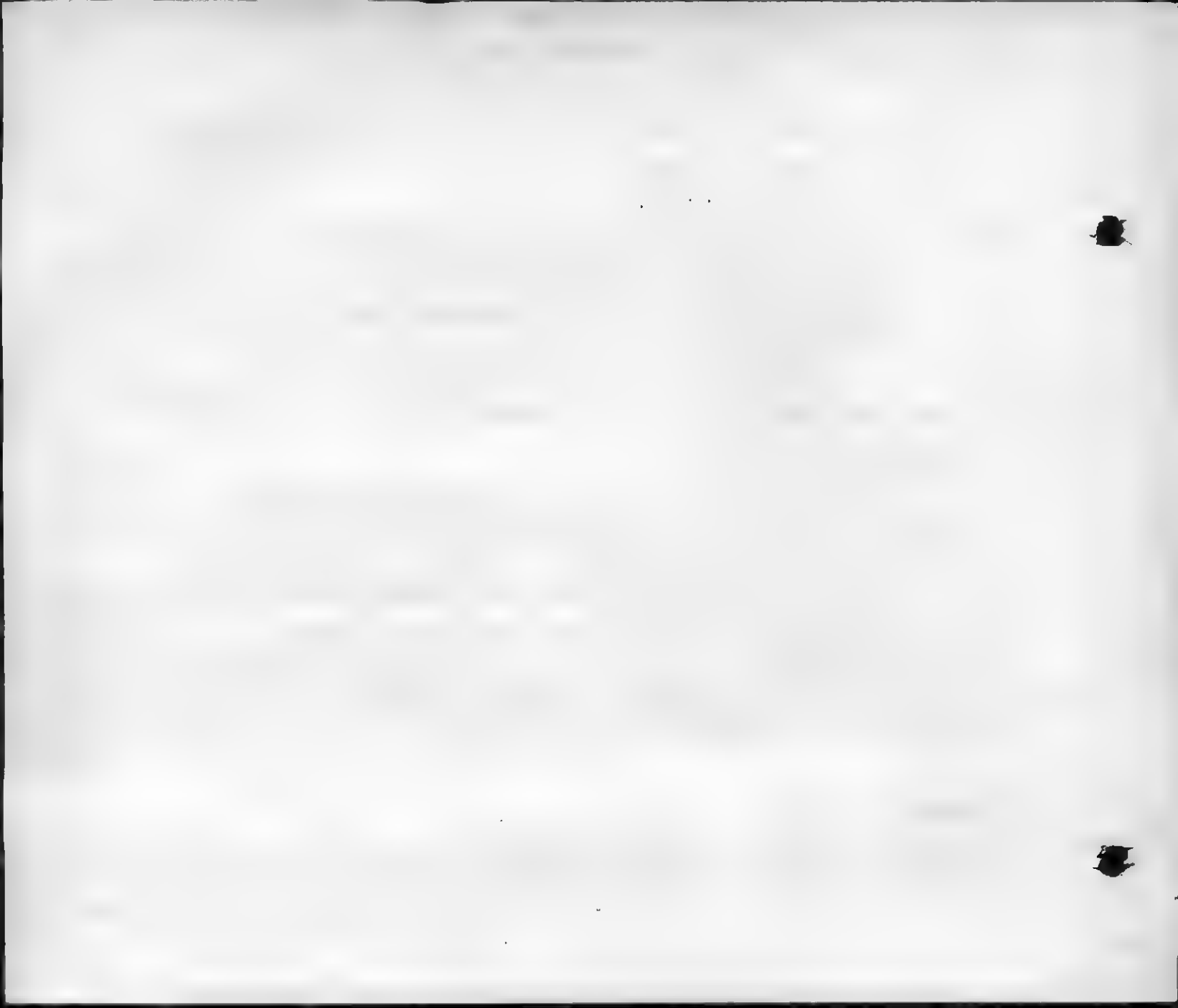
Reg. Dist. No.

| | | | |
|---|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>6 mos.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 Westover Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Lee</u> Middle <u>Greenman</u> Last <u>St.</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar 27 1914</u> |
| 9. AGE (In years last birthday) <u>43</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>17th St. Roads</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Eugene E. Greenman</u> | | 14. MOTHER'S MAIDEN NAME <u>Katherine Pearl</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>2-14-16-5740</u> | |
| 17. INFORMANT <u>Mr. E. J. Greenman</u> | | Address <u>same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>440.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Atherosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2-6-1958</u> to <u>1958</u> , that I last saw the deceased alive on <u>DOA</u> , 19 <u>58</u> , and that death occurred at <u>3:51</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Dr. H. J. Williams</u> | | DATE SIGNED <u>June 26 1958</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. H. J. Williams</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/30/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Greenwich Amador</u> | | ADDRESS <u>4600 Liberty Heights Ave. - 7</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE JUN 30 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6527

CERTIFICATE OF DEATH

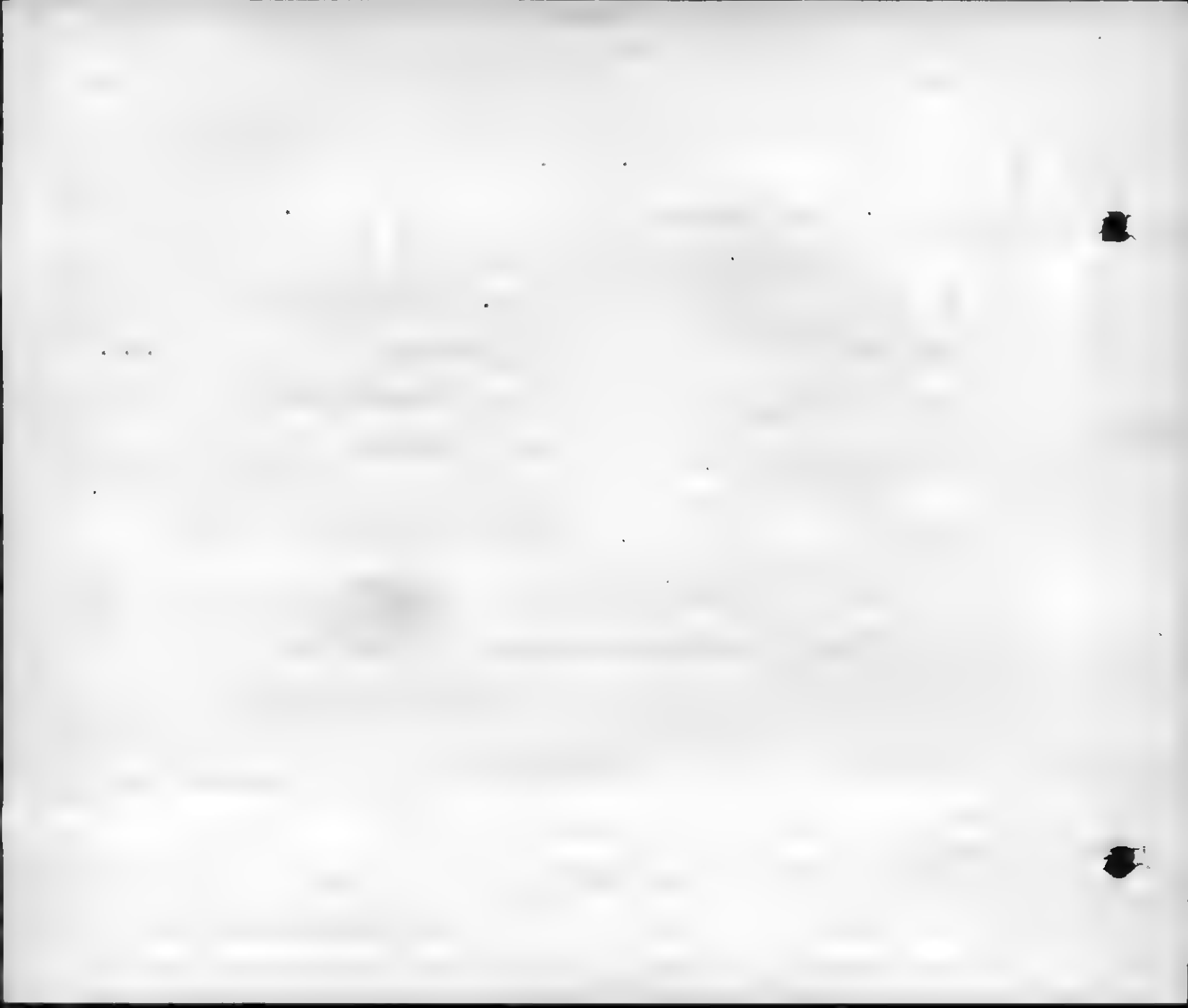
Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b Approx. 2 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice | | | | d. STREET ADDRESS 928 Gorsuch Ave. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Margaret Ann Martin Griffith | | | | 4. DATE OF DEATH Month Day Year June 23 19 58 | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 8, 1876 | |
| 9. AGE (In years last birthday) yrs. 82 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Patrick Martin | | 14. MOTHER'S MAIDEN NAME Margaret Murphy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Admission Record | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Hypertensive Cardio Renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease (c) 1042 | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 1957 to 1958 , that I last saw the deceased alive on June 20, 1958 , and that death occurred at 5:17 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William H. Donnell M.D. | | | | ADDRESS (Street, city or town, state) 2501 York Rd Baltimore Md | | | |
| PHYSICIAN'S NAME (Type) William H. Donnell | | | | DATE SIGNED June 24 1958 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| BURIAL | | June 27 1958 | | Cathedral Cem. | | Baltimore Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles Jenkins | | | | ADDRESS 2713 Kirk Ave | | 24a. REC'D BY REGISTRAR DATE JUN 26 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

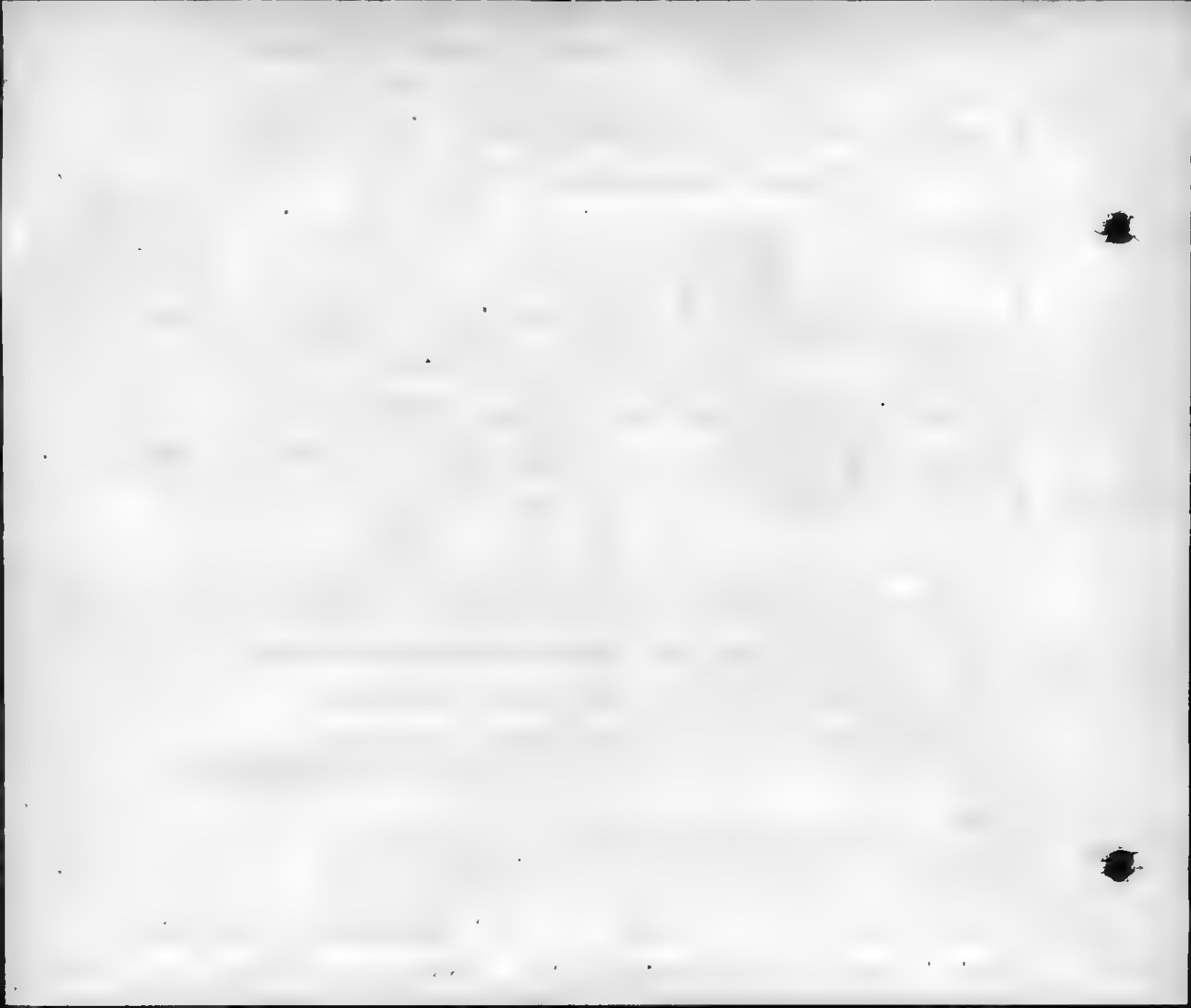
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06511

| | | | | | | | |
|---|---------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTO MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSP | | | | d. STREET ADDRESS 5814 Gwynn Oak Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LILLIAN First GRISWOLD Middle GRISWOLD Last | | | | 4. DATE OF DEATH JUNE 8 19 58 Month Day Year | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 4, 1891 | | 9. AGE (In years last birthday) 66 yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Insurance | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles H. Griswold | | | | 14. MOTHER'S MAIDEN NAME Letitia Moore | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Miss Olive C. Griswold - 5814 Gwynn Oak Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 471.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to incest Doriden and Marsilid DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Geo. S. M. Kieffer M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/11/58 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | 22d. LOCATION (City, town, or county) (State) Pikesville, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md. | | | | 24a. REC'D BY REGISTRAR JUN 9 '58 | | 24b. REGISTRAR'S SIGNATURE Qu... | |



6529

CERTIFICATE OF DEATH

06512

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, c. LENGTH OF STAY IN 1b 125 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY 3V01 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 736 N. Carrollton Avenue, Baltimore d. STREET ADDRESS 736 N. Carrollton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LUM Middle --- Last GROSS | | 4. DATE OF DEATH Month June Day 26 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 6, 1893 9. AGE (In years last birthday) 65 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Dairy Garage | 11. BIRTHPLACE (State or foreign country) Calvert Co., Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Edward Gross | | 14. MOTHER'S MAIDEN NAME Annie Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 216-01-8560 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathological fracture, left femur - 4 months. Operation, Open reduction-Intramedullary nail, left hip - 3/3/58 | | | INTERVAL BETWEEN ONSET AND DEATH 1 YEAR |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 58 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from February 21, 1958 , to June 26, 1958 , that I last saw the deceased on June 26, 1958 , and that death occurred at 11:35 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Irving Freeman M.D. VA HOSPITAL, FORT HOWARD, MARYLAND 6/27/58 PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 7-1-58 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) Baltimore, Maryland (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Address 802-04 Madison Ave. Baltimore 1, Md. | | 24a. REC'D BY REGISTRAR DATE JUL 1 '58 | 24b. REGISTRAR'S SIGNATURE Alfred Smith |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6530

CERTIFICATE OF DEATH

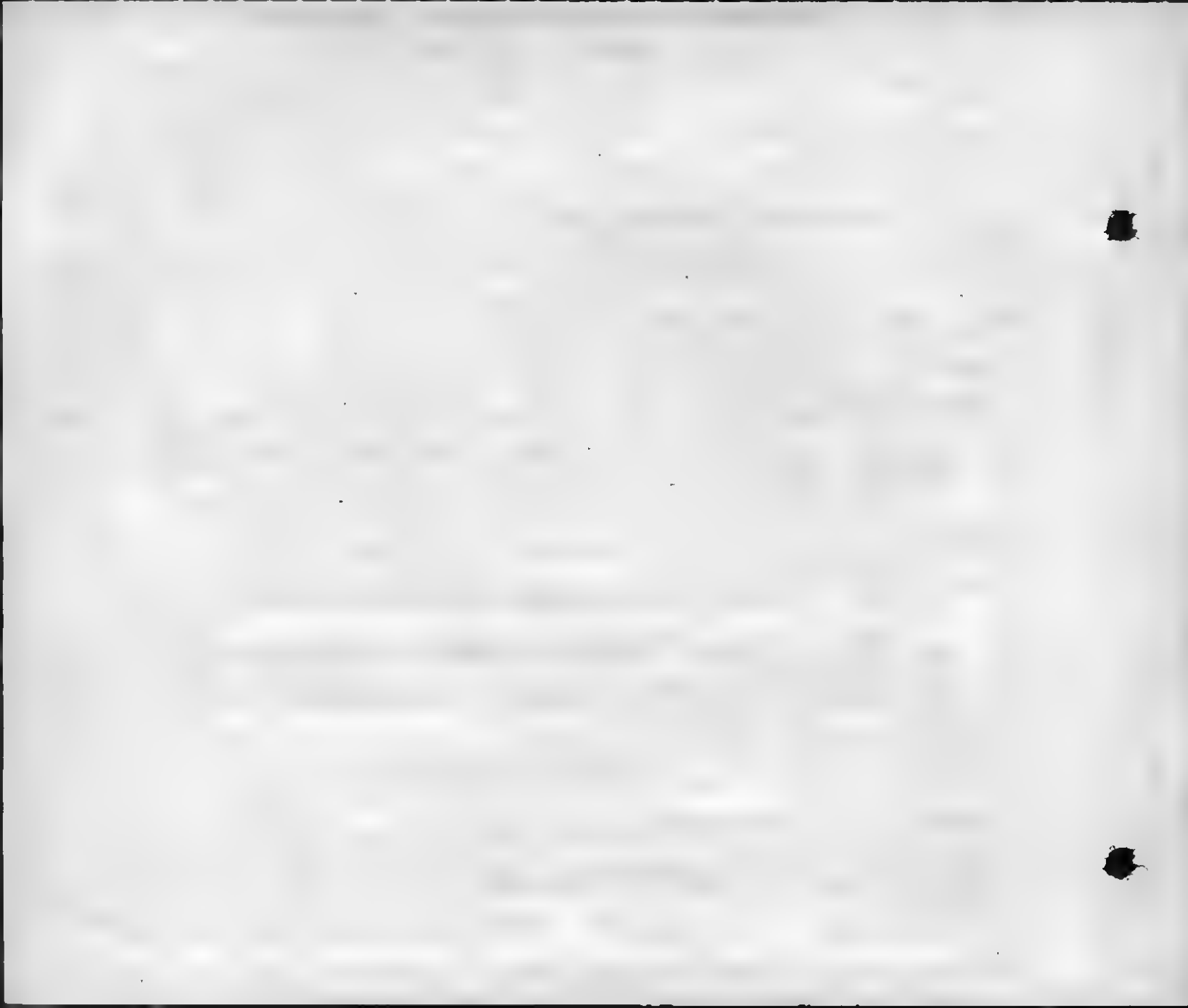
06513

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>3 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>904 Masfield Rd.</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>904 Masfield Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Benjamin G. H. Groves</u> First Middle Last | | 4. DATE OF DEATH <u>June 1st 1958</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 6th 1876</u> Month Day Year |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Southeyn Beef Co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Samuel Groves</u> | | 14. MOTHER'S MAIDEN NAME <u>Jane Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>✓</u> | | 16. SOCIAL SECURITY NO. <u>216-03-8395</u> | |
| 17. INFORMANT <u>Mrs Mary A. Groves</u> Address <u>904 Masfield Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Disease</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 5, 1948</u> to <u>June 1, 1958</u> , that I last saw the deceased alive on <u>June 1, 1958</u> , and that death occurred at <u>6:45</u> A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. J. Mendelis</u> PHYSICIAN'S NAME (Type) <u>C. J. Mendelis</u> | | ADDRESS (Street, city or town, state) <u>651 N. Broadway</u> DATE SIGNED <u>6/2/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/4/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Lem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan & Son</u> ADDRESS <u>11 Collins St.</u> | | 24a. REC'D BY REGISTRAR <u>W. H. H. H.</u> DATE <u>JUN 3 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6531

CERTIFICATE OF DEATH

Reg. Dist. No.

06514

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Falls Rd and Greenway Rd. | | | | d. STREET ADDRESS 1207 W. Belvedere Avenue | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle HALL Last GUETLER | | | | 4. DATE OF DEATH Month June Day 16 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 3, 1887 | |
| 9. AGE (In years last birthday) 70 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Spencer Thomas Oldham | | | | 14. MOTHER'S MAIDEN NAME Annie Elizabeth North | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT G. Earl Guetler, Falls and Greenway Rds., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH 2 YRS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Aug 1957 to June 1958 that I last saw the deceased alive on JUNE 15, 1958 , and that death occurred at 1 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William H. Pillsbury M.D. | | | | ADDRESS (Street, city or town, state) Towson, Md DATE SIGNED 6/18/58 | | | |
| PHYSICIAN'S NAME (Type) WILLIAM H. PILLSBURY | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 19, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 22d. LOCATION (City, town, or county) (State) Pikesville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland | | | | 24a. REC'D BY REGISTRAR DATE JUN 19 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. Smith | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6532

CERTIFICATE OF DEATH

Reg. Dist. No. 06515

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO COUNTY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10011 HARFORD RD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BALTO MD.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10011 HARFORD RD</u> | | d. STREET ADDRESS <u>10011 HARFORD RD</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ANITA</u> Middle <u>HATZELER</u> Last <u>HATZELER</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>11</u> Year <u>1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 11-1875</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>XXXXXXXXXXXXXXXXXXXX</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>XXXXXXXXXXXXXXXXXXXX</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13. FATHER'S NAME <u>JOHN ROSE GERMANY BORN</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie GERMAN BORN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr and Mrs Howard H Hatzeler</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, Duod ulcer hem.</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) <u>Arterial sclerosis Myocarditis</u> DUE TO (c) <u>INTESTINAL HEMORRHAGE 7 days ago</u> 1 week ago | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LKG shows posterior infarction, Ulcer gastric(?)</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6-18-'58</u> , 19 <u>58</u> , to <u>6-28-'58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-28-'58</u> , 19 <u>58</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>321 DUNKIRK RD.</u> DATE SIGNED <u>Chas. Victor Richards</u> | | | |
| ACTUAL SIGNATURE <u>Chas. Victor Richards</u> | | PHYSICIAN'S NAME (Type) <u>Chas. Victor Richards</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>7-2-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u> | 22d. LOCATION (City, town or county) (State) <u>Balto Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuck</u> ADDRESS <u>5305 Harford</u> | | 24a. REC'D BY REGISTRAR <u>DATE JUL 1 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Aw. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

653 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06516

Reg. Dist. No.

| | | | | | | | | | | | | |
|---|------------------|--|--|--|------------------|---|------------|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wayne Nursing Home, Summit Smithwood Ave</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 5</u> d. STREET ADDRESS <u>217 Oak Forest Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Haertig</u> Last <u></u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1958</u> | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | |
| 8. DATE OF BIRTH <u>April 21, 1881</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table> | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months Days | Hours Min. | | | | | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | |
| Months Days | Hours Min. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>floor cover</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pitts. Penn</u> | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>August William Haertig</u> | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME <u>Martha Andrews</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 17. INFORMANT Address <u>Mrs. Robt. Bragg 217 Oak Forest Ave</u> | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cariac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="2"> (b) <u>Hypertansive Cardiovascular Disease</u> DUE TO </td> </tr> <tr> <td colspan="2"> (c) <u>Fracture of Left Femur Accident</u> </td> </tr> </table> | | | | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cariac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | (b) <u>Hypertansive Cardiovascular Disease</u> DUE TO | | (c) <u>Fracture of Left Femur Accident</u> | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cariac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| (b) <u>Hypertansive Cardiovascular Disease</u> DUE TO | | | | | | | | | | | | |
| (c) <u>Fracture of Left Femur Accident</u> | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture corrected by operation May 1958</u> | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fell on the street causing a fracture of his hip;</u> | | 20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u></u> p. m. <u>May 17, 48</u> | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Public Street</u> | | 20f. (City or town) (County) (State) <u>Catonsville Balto. Co. Md.</u> | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D. NAME (Type) <u>Geo. S. M. Kieffer M.D.</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 22b. DATE THEREOF <u>6/9/1958</u> | | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton! Sons</u> | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u> | | | | | | | | | |
| ADDRESS <u>Catonsville, Md.</u> | | | 24b. REGISTRAR'S SIGNATURE <u>W. E. Leach</u> | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6534

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>16 X - 2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State Hospital</u> | | e. STREET ADDRESS <u>6108 Craig Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Willat</u> Middle <u>Halstead</u> Last <u>Halstead</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>19 58</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-10-81</u> |
| 9. AGE (In years last birthday) <u>76</u> yrs | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Mural Halstead</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Bangs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Records Spring Grove Hospital</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>long standing</u> (c) <u>fracture of left femur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Accident</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>11</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while walking on floor</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>5-3-6-12-58</u> Hour <u> </u> p. m. <u> </u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>SSH</u> | 20f. (City or town) (County) (State) <u>Catonsville Baltimore</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>GEO. S. M. KIEFFER MD</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u> | | DATE <u>June 16-58</u> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/19/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Colesville Methodist</u> | 22d. LOCATION (City, town, or county) (State) <u>Colesville Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> | | ADDRESS <u>Wyattsville Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JUN 20 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



06518

| | | | | | | | | | | |
|---|---|---|---|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30, Maryland | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30, Maryland | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Leslie | Middle Lucille | Last Harris | 4. DATE OF DEATH Month 6 | Day 5 | Year 19 58 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/23/58 | 9. AGE (In years last birthday) yrs. 4 | IF UNDER 1 YEAR: IF UNDER 24 HRS Months 4 | Days 5 | Hours | Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY U.S.A. | 13. FATHER'S NAME Joseph Edward Harris | 14. MOTHER'S MAIDEN NAME Patricia Sue Martin | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO | 17. INFORMANT Rosewood Records | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia 101X DUE TO aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hydrocephalus (Arnold Chiari) (c) Spina bifida Septicemic | INTERVAL BETWEEN ONSET AND DEATH quick | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/20/58 , 19 58 , to 6/5/58 , 19 58 , that I last saw the deceased alive on 6/5/58 , 19 58 , and that death occurred at 7:25 PM , from the causes and on the date stated above | ACTUAL SIGNATURE Larry G. Butler | M.D. Cummings Mills, Md | ADDRESS (Street, city or town, state) | DATE SIGNED 6/6/58 | PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. | Rosewood State Training School | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/9/58 | 22c. NAME OF CEMETERY OR CREMATORY Balto. National | 22d. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Cause, Funeral Home 1216 S. Charles St. Balto 30 Md | ADDRESS | 24a. REC'D BY REGISTRAR DATE JUN 10 '58 | 24b. REGISTRAR'S SIGNATURE Dist. Clerk | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6469

CERTIFICATE OF DEATH

Reg. Dist. No.

06519

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|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County Dundalk MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY 1 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turners Station | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 413 Maple Lane | | d. STREET ADDRESS 413 Maple Lane | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mary (Marie) Middle Harris Last Harris | | 4. DATE OF DEATH Month June Day 21 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 31, 1883 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Cumberland, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Beverley Coleman | | 14. MOTHER'S MAIDEN NAME Lucy Coleman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO None | |
| 17. INFORMANT George McNair - 413 Maple Lane | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Asthma & Hypertension DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 day Indefinite | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1958 to June 21/58 , that I last saw the deceased alive on June 21-58 , and that death occurred at 4 M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 107 N. Main St. Baltimore Md | |
| ACTUAL SIGNATURE Dr. Thomas | | DATE SIGNED | |
| PHYSICIAN'S NAME (Type) Dr. Thomas | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-25-58 | 22c. NAME OF CEMETERY OR CREMATORY Cumberland Baptist Church | 22d. LOCATION (City, town, or county) (State) Cumberland, Virginia |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | ADDRESS 802 Madison Avenue | |
| 24a. REC'D BY REGISTRAR DATE JUN 25 '58 | | 24b. REGISTRAR'S SIGNATURE Qu. Lewis | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, film 0 231 7-23/58 4m

CERTIFICATE OF DEATH

Reg. Dist. No. 06520

6536

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|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO. 21</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> | | | | c. LENGTH OF STAY IN 1b <u>BALTO. 21</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>327 E. RIVERSIDE RD.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>WINIFRED</u> First Middle Last | | | | 4. DATE OF DEATH <u>June 29</u> 1958 | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1892</u> <u>APRIL 2, 1892</u> | |
| 9. AGE (In years past birthday) <u>67</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>PATRICK HUGHES</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY BAUMASH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO | | 17. INFORMANT <u>JAMES HUGHES</u> Address <u>552 HAMPTON-LANE BALTO. 4</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Bronchial asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>10 yrs</u> | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 28</u> , 1958, to <u>June 29</u> , 1958, that I last saw the deceased alive on <u>June 29</u> , 1958, and that death occurred at <u>8 A</u> . M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. B. Cunningham</u> | | | | ADDRESS (Street, city or town, state) <u>BALTO. 6 MD.</u> | | DATE SIGNED <u>6/29/58</u> | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JULY 2, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Connelly</u> ADDRESS <u>418 Eastern Blvd. BALTO.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUL 2 '58</u> | | 24b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06521**

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN lb 4 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 2602 LEHMAN STREET | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle J Last HASLETT | | 4. DATE OF DEATH Month JUNE Day 25 Year 19 58 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 28, 1908 |
| 9. AGE (In years last birthday) 49 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAKER | | 10b. KIND OF BUSINESS OR INDUSTRY Watch Repairing | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM HASLETT | | 14. MOTHER'S MAIDEN NAME BARBARA SIEGLEIN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO 215-10-2288 | |
| 17. INFORMANT CLIN REC VET ADM HOSP FT HOWARD MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERIOSCLEROSIS SEVERE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) COR PULMONALE (c) GENERALIZED ARTERIOSCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH 15 YEARS UNKNOWN UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JUNE 21, 1958 , to JUNE 25, 1958 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) VAH FORT HOWARD MARYLAND DATE SIGNED 6-25-58 ACTUAL SIGNATURE Chien Wei Lan M.D. PHYSICIAN'S NAME (Type) CHIEN WEI LAN M.D. VAH FORT HOWARD MARYLAND 6-25-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-28-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab | | 24a. REC'D BY REGISTRAR JUN 27 '58 | |
| 24b. REGISTRAR'S SIGNATURE Barbara M. Schwab | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6538

CERTIFICATE OF DEATH

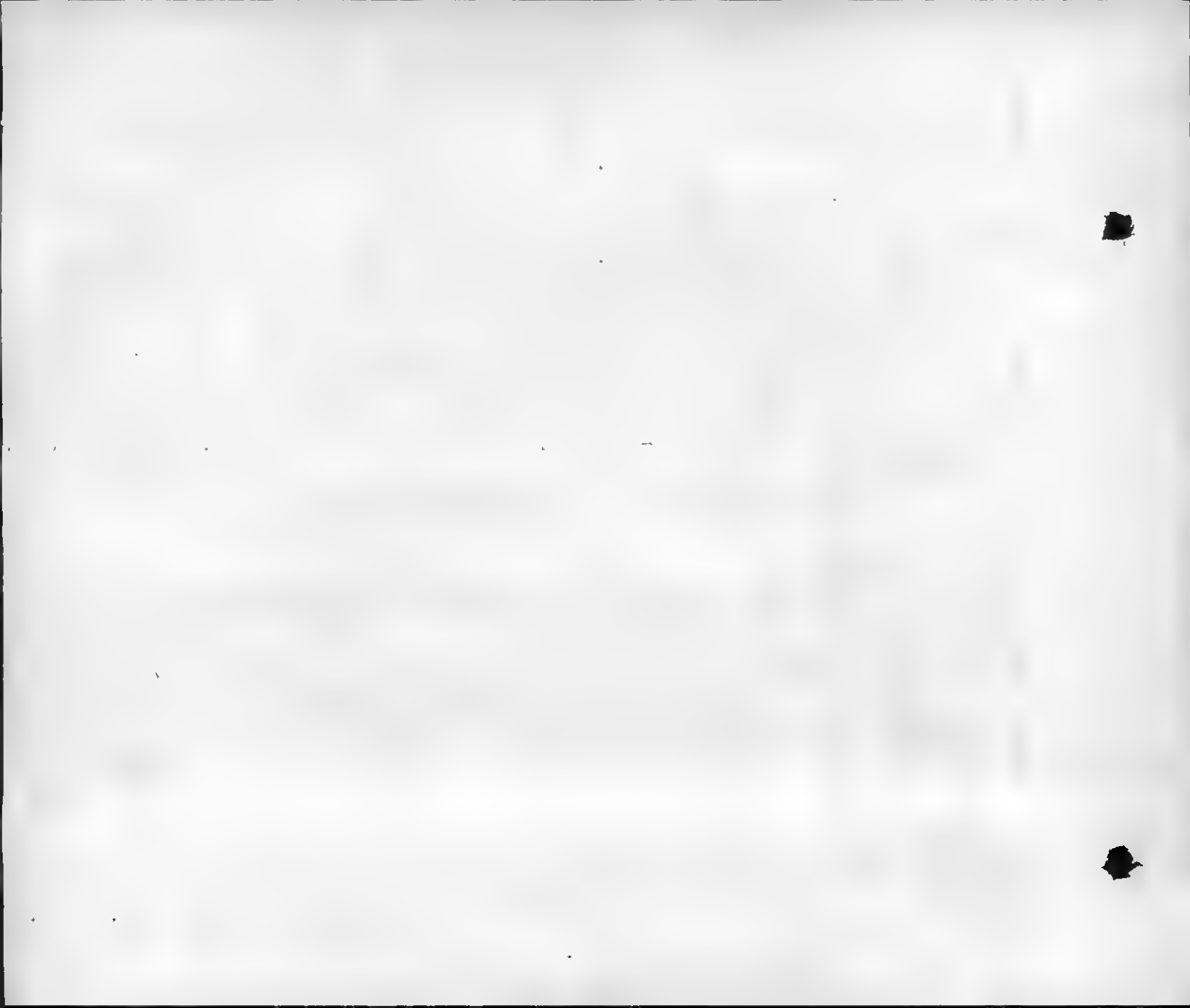
Reg. Dist. No.

06522

| | | | | | | | |
|--|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b 12 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 408 Locust Drive | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Alma Middle B. Last Hause | | | | 4. DATE OF DEATH Month June Day 5th. Year 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 18, 1917 | | 9. AGE (In years lost birthday) yrs. 40 | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13. FATHER'S NAME Martin Buchinsky | | | |
| 14. MOTHER'S MAIDEN NAME Annie Strab (Strolis) | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO 182-16-5942 | | | | 17. INFORMANT Mr. Francis Hause 408 Locust Dr. Catonsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leucemia, probably uterine, with g. - 14-1 114X DUE TO abdominal metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 min. 20 sec. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from March, 1958 , to June 5, 1958 , that I last saw the deceased alive on June 5, 1958 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St. Paul St. Baltimore 2, Maryland DATE SIGNED 6-6-58 | | | | | | | |
| ACTUAL SIGNATURE John A. Nesbitt, Jr. M.D. | | | | PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6/9/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Charles Baber Cemetery | | 22d. LOCATION (City, town, or county) (State) Pottsville Schuylkill Co. Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons | | | | ADDRESS Catonsville - 28, Md. | | 24a. REC'D BY REGISTRAR JUN 9 '58 | |
| 24b. REGISTRAR'S SIGNATURE Alfred Smith | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6539

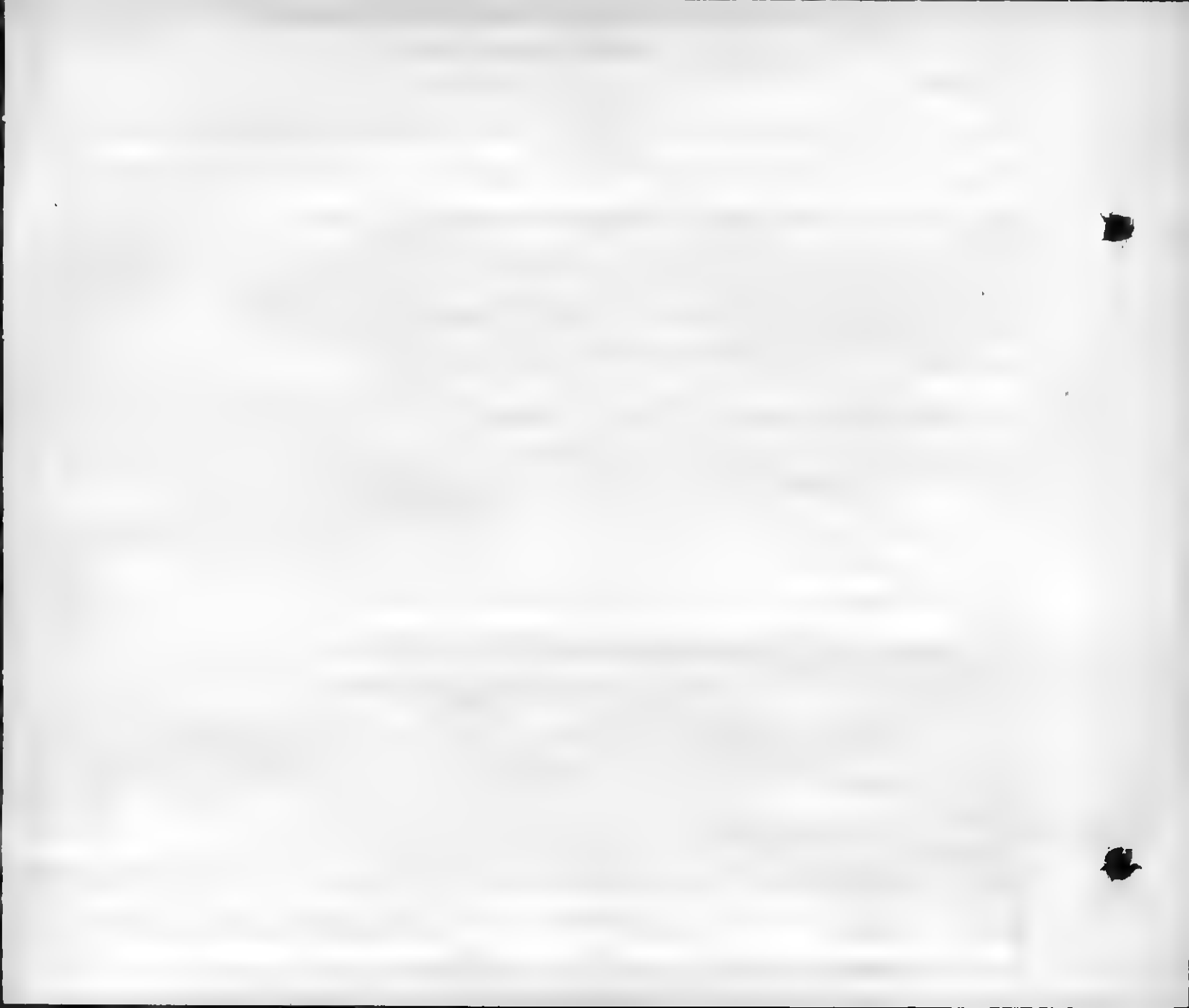
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore - 19</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>as</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u> | | | | c. LENGTH OF STAY IN 1b <u>25 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>in</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 Oak Rd.</u> | | | | d. STREET ADDRESS <u>#1.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF <u>JOHN</u> First Middle Last <u>HEIKKILA</u> | | | | 4. DATE OF DEATH <u>June 9</u> 19 <u>58</u> Month Day Year | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 1, 1885</u> | |
| 9. AGE (in years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mill</u> | | 11. BIRTHPLACE (State or foreign country) <u>Finland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>213-07-3923</u> | | 17. INFORMANT <u>Self</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO <u>10 yrs</u> | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Oct 18</u> , 19 <u>57</u> , to <u>June 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>58</u> , and that death occurred at <u>6408 North Pt. Rd</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Louis N. Tollen</u> M.D. | | | | DATE SIGNED <u>6/9/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Louis N. Tollen</u> | | | | <u>Baltimore - 19 - Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/12/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Co., MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Whitehead & Son</u> ADDRESS <u>DUNDALK</u> | | | | 24a. REC'D BY REGISTRAR <u>DATE JUN 12 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6540 CERTIFICATE OF DEATH

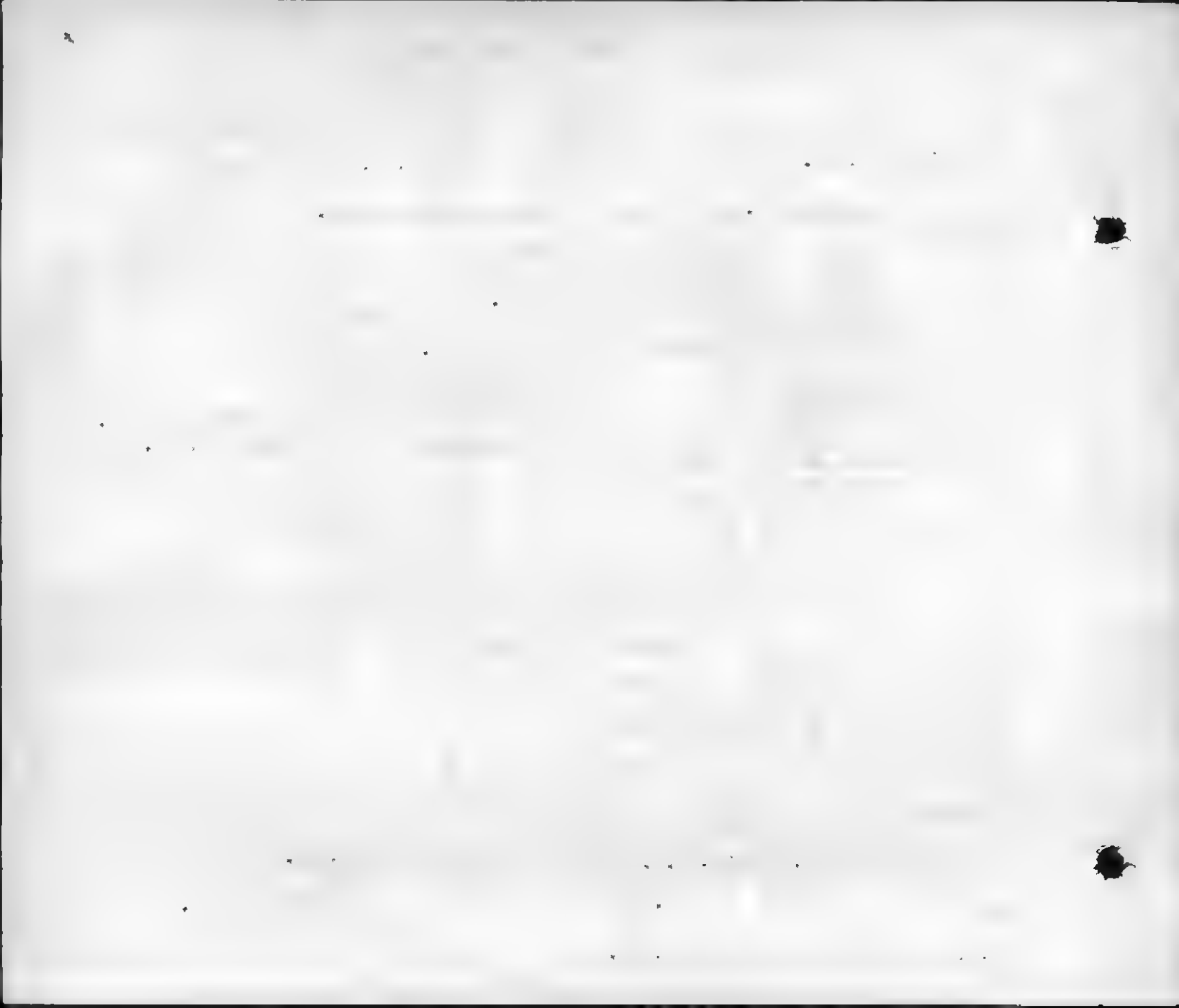
Reg. Dist. No.

06524

| | | | |
|---|-------------------------------|--|-------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7, Md. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 7, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5922 Johnny Cake Rd. | | d. STREET ADDRESS 5922 Johnny Cake Rd. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) MARY BELLE HENDERSON | | 4. DATE OF DEATH June 5 1958 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 9 1884 |
| 9. AGE (In years last birthday) 73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY housewife | |
| 11. BIRTHPLACE (State or foreign country) Tenn. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME William Ledbetter | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Harry Henderson | | Address 5922 Johnny Cake Rd. Baltimore 7, Md. | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arterio-sclerotic Cardio-vascular disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 15 min 15 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Feb. 3 1958 to June 5 1958 , that I last saw the deceased alive on June 5 1958 , and that death occurred at 10:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 6/6/58 | | | |
| ACTUAL SIGNATURE Thomas F. Herbert M.D. | | DATE SIGNED 6/6/58 | |
| PRINTED NAME (Type) Thomas F. Herbert, M.D. | | Ellicott City, Md. | |
| 22a. BURIAL, CREMATON, REMOVAL (Specify) burial | | 22b. DATE THEREOF 6/8/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Johns | | 22d. LOCATION (City town, or county) (State) Ellicott City, Md. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE F.C. HIGINBOTHOM ADDRESS Ellicott City, Md. | | 24a. REC'D BY REGISTRAR DATE JUN 9 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Alfred Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6541

CERTIFICATE OF DEATH

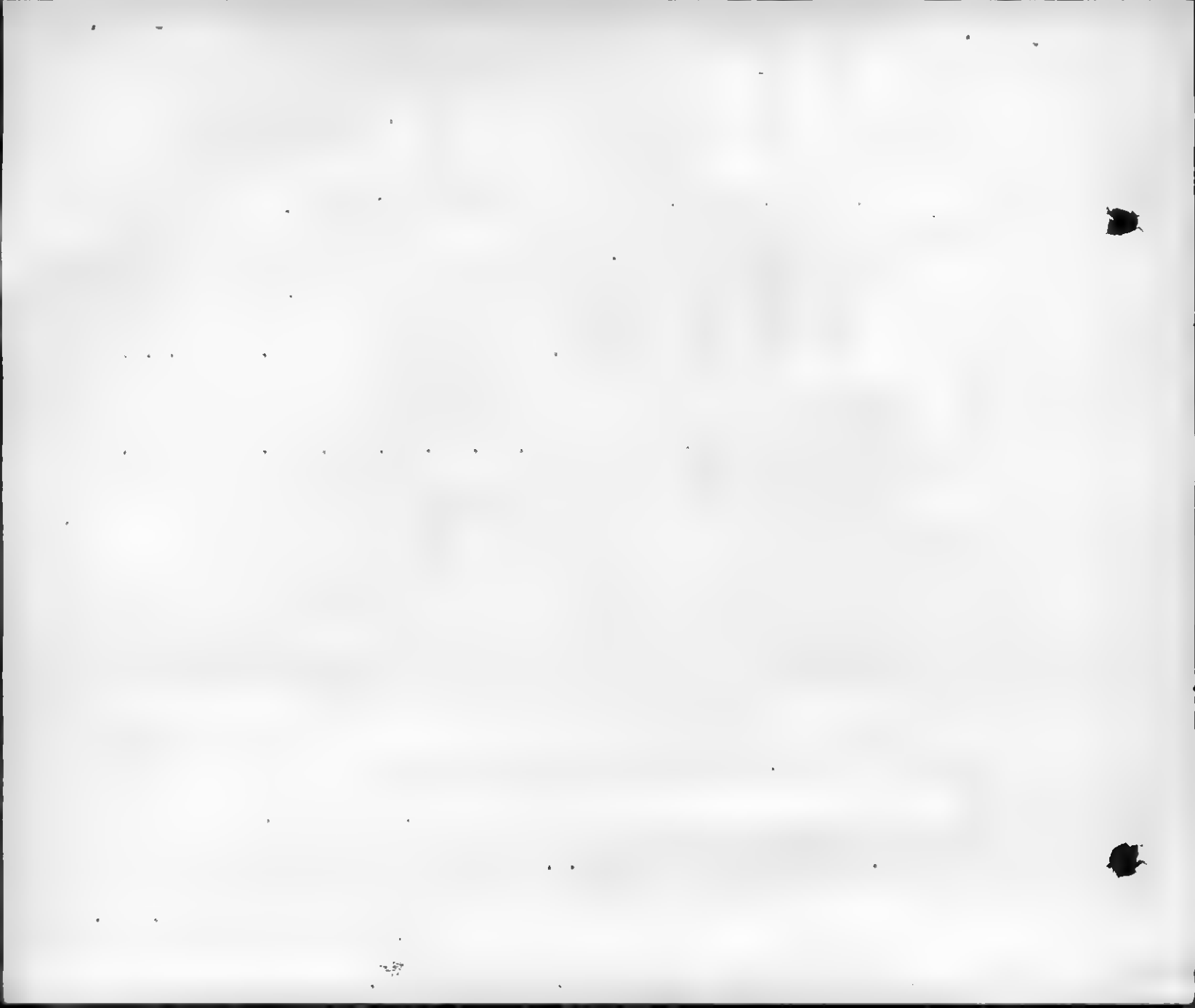
06525

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE Maryland. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 25 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle R. Last HENSON | | | | 4. DATE OF DEATH Month June Day 7 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 30, 1886 | |
| 9. AGE (In years last birthday) 71 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler | | | | 10b. KIND OF BUSINESS OR INDUSTRY Private Homes. | | 11. BIRTHPLACE (State or foreign country) Baltimore, d Maryland. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William Henson | | | | 14. MOTHER'S MAIDEN NAME Kate Kellem | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | | | | 16. SOCIAL SECURITY NO 217-18-0014 | | 17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO CEREBRO-VASCULAR ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) _____ (c) _____ | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that VA attended the deceased from May 13 , 19 58 , to June 7 , 19 58 and that death occurred at 3:10A M, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) VAH. FT. HOWARD, MD. DATE SIGNED 6/7/58 | | | | | | | |
| ACTUAL SIGNATURE Dr. Rolando PONCE de LEON, M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Dr. Rolando PONCE de LEON, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF June 10, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Brederick National | |
| 22d. LOCATION (City, town, or county) (State) Brederick Rd, Balto., Md. | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Johnson | | | | ADDRESS 1700 Druid Hill Ave. | | 24a. REC'D BY REGISTRAR JUN 9 '58 | |
| 24b. REGISTRAR'S SIGNATURE John M. Johnson | | | | | | | |

JOHN M. JOHNSON, 1700 Druid Hill Ave., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06526**

6542

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Balto. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 103 A Dumbarton Rd. | | d. STREET ADDRESS 103 A Dumbarton Rd. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sarah Elizabeth Henthorn | | 4. DATE OF DEATH Month Day Year June 23 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1883 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Adam J. Brandau | | 14. MOTHER'S MAIDEN NAME Johanna Schaal | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. Joseph T. Henthorn | | Address 103 A Dumbarton Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/26/58 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. |
| | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Lickens & Sons - Balto | | 24a. REC'D BY REGISTRAR DATE JUN 26 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur | |

I

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

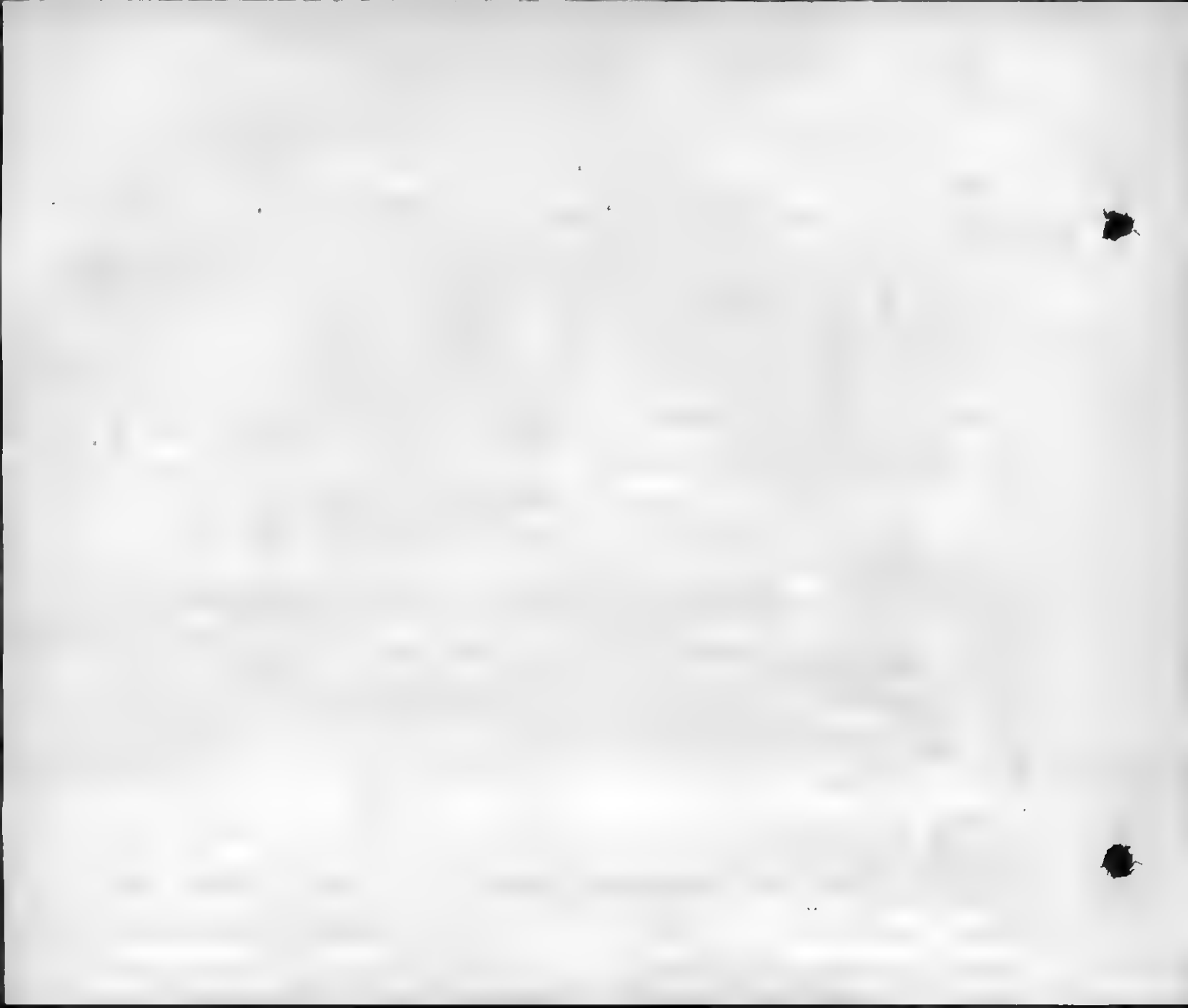
6543

CERTIFICATE OF DEATH

06527

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institut on. Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> | | c. LENGTH OF STAY IN lb <u>20 YRS.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>208 Reisterstown Rd.</u> | | d. STREET ADDRESS <u>208 Reisterstown Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>A.</u> Last <u>HERETICK</u> | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT 21, 1882</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH HUCIK</u> | | 14. MOTHER'S MAIDEN NAME <u>JOHANNA ZAJAK</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>IRENE HERETICK, 208 Reisterstown RD.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE FAILURE</u> <u>526X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>CHRONIC BRONCHIECTASIS, BILATERAL</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u> </u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>MAY 14, 1958</u> to <u>JUNE 12, 1958</u> , that I last saw the deceased alive on <u>JUNE 12, 1958</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1331 REISTERSTOWN ROAD PIKESVILLE 8, MD.</u> DATE SIGNED <u>6/5/58</u> ACTUAL SIGNATURE <u>Samuel P. Scalia</u> M.D. PHYSICIAN'S NAME (Type) <u>SAMUEL P. SCALIA</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-17-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ST. CHARLES</u> | | 22d. LOCATION (City, town, or county) (State) <u>PIKESVILLE, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Russell</u> | | ADDRESS <u>Pikesville, Md.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JUN 17 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **06528**

6544

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | |
| c. LENGTH OF STAY IN 1b 18yrs | | | | d. STREET ADDRESS 623 Register Ave | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 623 Register Ave | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle S Last Heuter | | | | 4. DATE OF DEATH Month June Day 7 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov-13-1865 | |
| 9. AGE (In years last birthday) 92 yrs. | | IF UNDER 1 YEAR Months 7 Days 12 Hours 12 Min. | | IF UNDER 24 HRS Months 7 Days 12 Hours 12 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph operator Bto Railroad | | | | 10b. KIND OF BUSINESS OR INDUSTRY MD | | | |
| 11. BIRTHPLACE (State or foreign country) MD | | | | 12. CITIZEN OF WHAT COUNTRY? U S A. | | | |
| 13. FATHER'S NAME Charles Carl Heuter | | | | 14. MOTHER'S MAIDEN NAME Catherine Klace | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT William Miller 623 Register Ave | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) 5 months | | | | INTERVAL BETWEEN ONSET AND DEATH 5 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Baltimore | | | | 20g. (County) md | | 20h. (State) md | |
| 21. I certify that I attended the deceased from June 22, 1958 to June 7, 1958 , that I last saw the deceased alive on June 22, 1958 , and that death occurred at 3:40 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1261 E Belvedere Ave DATE SIGNED ACTUAL SIGNATURE Sol Smith M.D. PHYSICIAN'S NAME (Type) Sol Smith Baltimore 12 Md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/10/1958 | | 22c. NAME OF CEMETERY OR CREMATORY BALTIMORE | | 22d. LOCATION (City, town, or county) (State) BALTIMORE md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Glenn F. Seitz 5209 York Rd. | | | | 24a. REC'D BY REGISTRAR DATE JUN 10 1958 | | 24b. REGISTRAR'S SIGNATURE W. Seitz | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

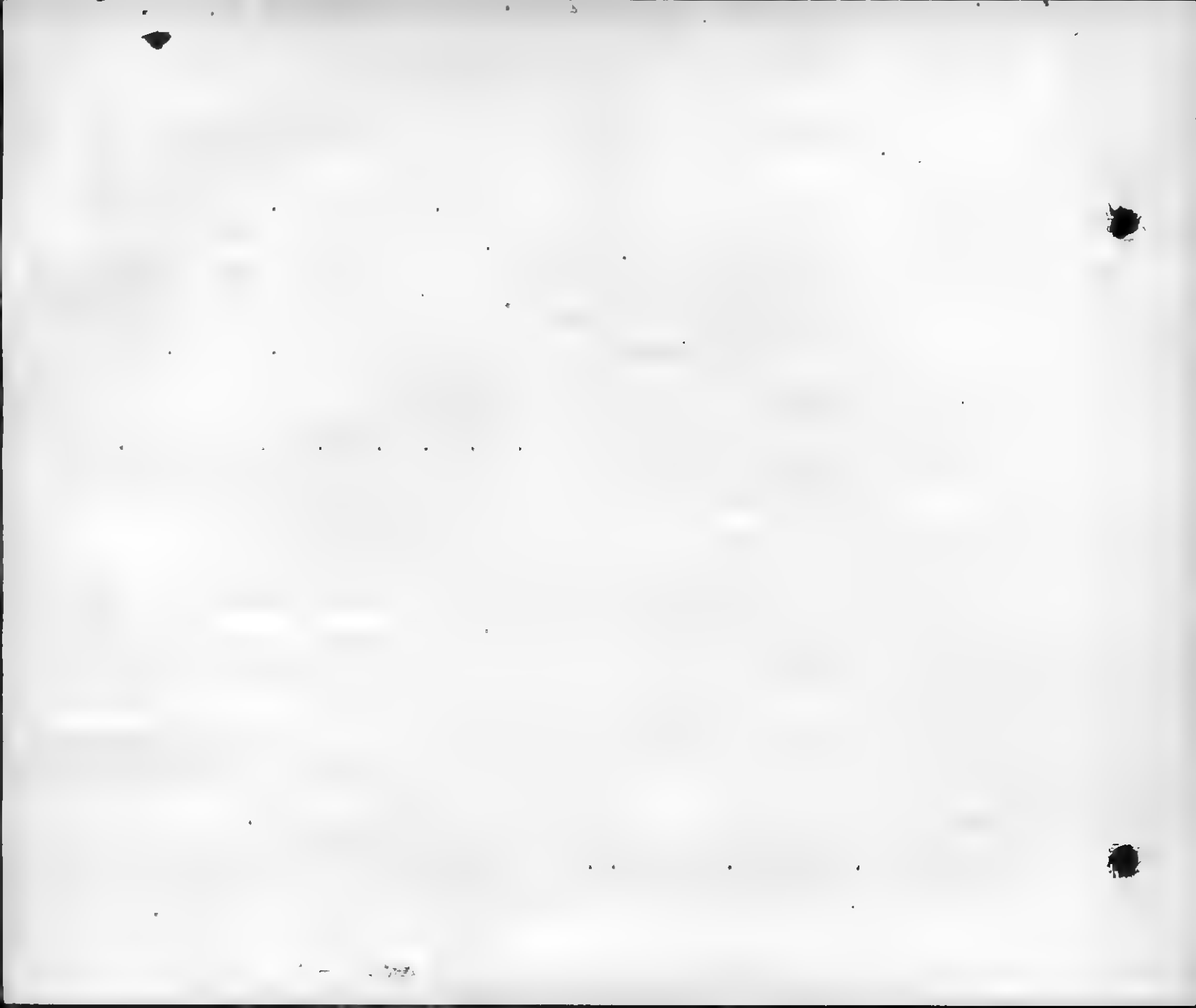
06529

6545

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 18 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1806 E. Baltimore St., e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle A. Last HILLEBRAND | | 4. DATE OF DEATH Month June Day 6 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 1, 1889 |
| 9. AGE (In years last birthday) 69 yrs | | IF UNDER 1 YEAR Months 69 Days 6 Hours 19 Min 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10b. KIND OF BUSINESS OR INDUSTRY Printers | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Hillebrand | | 14. MOTHER'S MAIDEN NAME Mary Sahn | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO (If yes, give war or dates of service) WW I 212-01-6607 | |
| 17. INFORMANT Clin/Rec.Vet.Adm.Hosp., Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBOPHLEBITIS RIGHT EXTERNAL ILIAC VEIN DUE TO (c) CARCINOMA OF GALL BLADDER WITH ABDOMINAL METASTASES. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABDOMINAL ANEURISM WITH OCCLUSIVE THROMBUS. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 19 , 19 58 , to June 6 , 19 58 , and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort Howard, Maryland. DATE SIGNED 6/7/58 | | | |
| ACTUAL SIGNATURE C. T. Fitch | | PHYSICIAN'S NAME (Type) Dr. Charles T. FITCH, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-10-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town or county) (State) Frederick Rd, Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight, Inc. | | ADDRESS William Cook-Blight 6009 Harford Rd, Balto., Md. | |
| 24a. REC'D BY REGISTRAR JUN 9 58 | | 24b. REGISTRAR'S SIGNATURE Wm. Cook | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6546

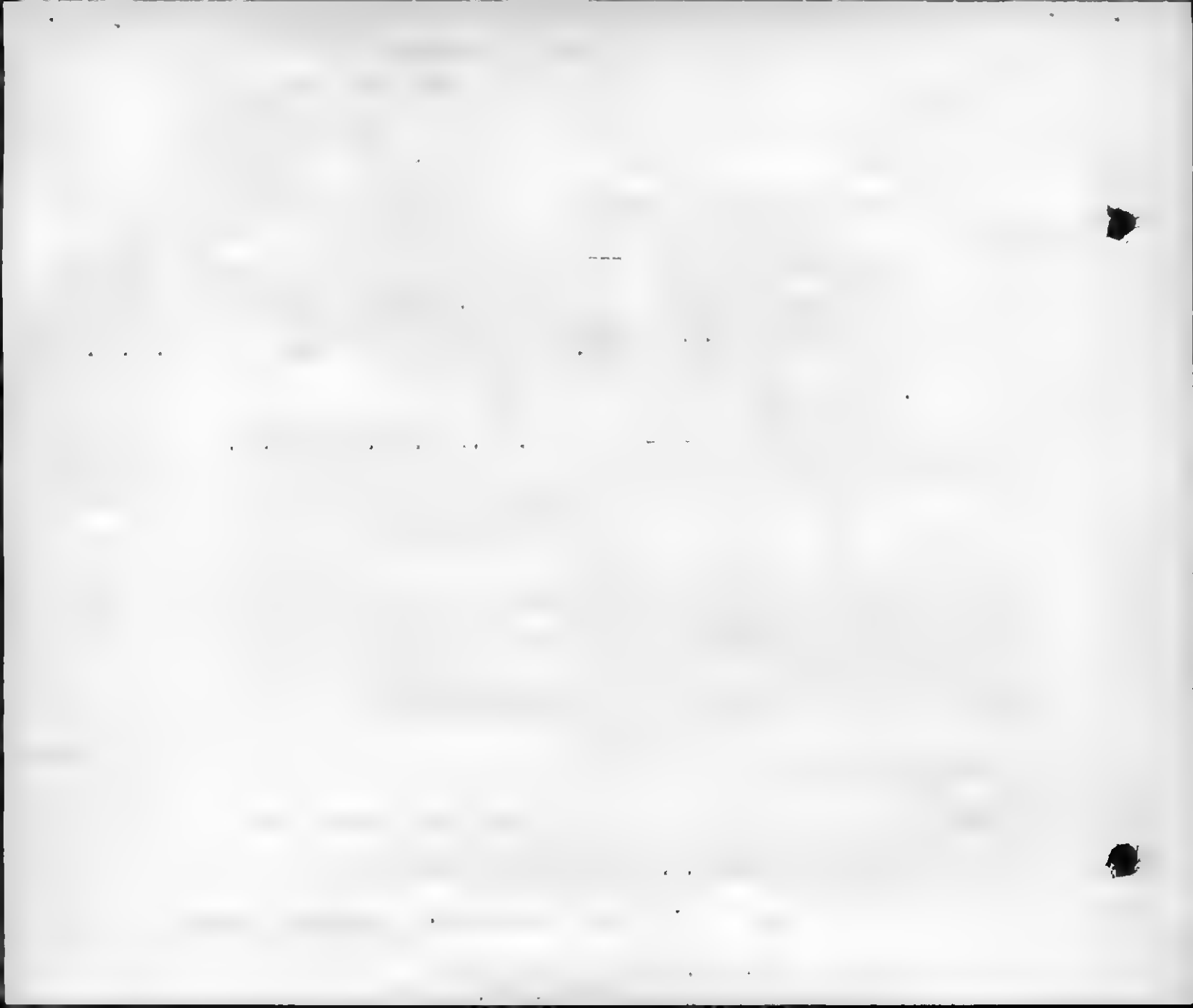
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 64 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 34-1-4 | |
| f. STREET ADDRESS 1521 Friendship Street | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First FRANK Middle HOEHN Last HOEHN | | 4. DATE OF DEATH Month June Day 13 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 6, 1896 |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government Veterans Adm. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Frank M. Hoehn | | 14. MOTHER'S MAIDEN NAME Mary Fury | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO 212-03-9180 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DIABETES MELLITUS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS 1 YEAR 10 YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy. Operation: Supra-retropubic Prostatectomy - 1/30/58 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 10 , 19 58 , to June 13 , 19 58 . XXXXXX and that death occurred at 3:10 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Irving Freeman | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | |
| DATE SIGNED 6/13/58 | | | |
| SIGNATURE NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/17/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry Sanders and Sons, Inc. North Ave. & Broadway Balto., Md. | | 24a. REC'D BY REGISTRAR DATE JUN 17 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. H. ... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3, and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, on in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be furnished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6547

CERTIFICATE OF DEATH

Reg. Dist. No.

06531

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) b. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 18 Hours | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore 3 V | |
| d. STREET ADDRESS 16 East Gittings Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First IRVIN Middle S. Last HOGENSON | | 4. DATE OF DEATH Month June Day 18 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 1, 1893 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer | | 9b. KIND OF BUSINESS OR INDUSTRY Automobile Interior | 9. AGE (In years last birthday) yrs 64 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer | | 10b. KIND OF BUSINESS OR INDUSTRY Automobile Interior | 11. BIRTHPLACE (State or foreign country) Ephraim, Wisconsin |
| 13. FATHER'S NAME John Hogenson | | 14. MOTHER'S MAIDEN NAME Matilda Thorgenson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 183-07-3885 | |
| 17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). CARCINOMA OF THE CECUM | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| MULTIPLE PULMONARY EMBOLI | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9:25PM, 6/17, 19 58 to June 18, 19 58 , and that death occurred at 3:35PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Donald D. Mark</i> | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 6/19/58 | |
| PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-23-58 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE James L. McCully | | ADDRESS 128 E. Fort Ave. Balto. Md | 24a. REC'D BY REGISTRAR JUN 20 '58 |
| | | 24b. REGISTRAR'S SIGNATURE <i>John A. Smith</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6548

CERTIFICATE OF DEATH

06532

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> | | c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u> | | d. STREET ADDRESS <u>5611 Laurelton Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ANNA K. JANNUSCH</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 10, 1875</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Conrad Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Louisa Weinreich</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mrs. Louise M. Ulrickson</u> | | Address <u>5611 Laurelton Ave.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Thrombosis Left</u> (c) <u>Cerebral Sclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hr</u> <u>4 days</u> <u>Unknown</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of Left Breast</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 10, 1956</u> to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>Cliff Ratliff Jr.</u> | | ADDRESS (Street, city or town, state) <u>4603 Edmonson Ave</u> DATE SIGNED <u>6/21/58</u> | |
| PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR</u> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>June 24, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. Carmel</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> | | ADDRESS <u>7401 Belair Rd.</u> | |
| 24a. REC'D BY REGISTRAR <u>JUN 24 '58</u> | | 24b. REG. STAFF'S SIGNATURE <u>W. H. H. H.</u> | |



6549

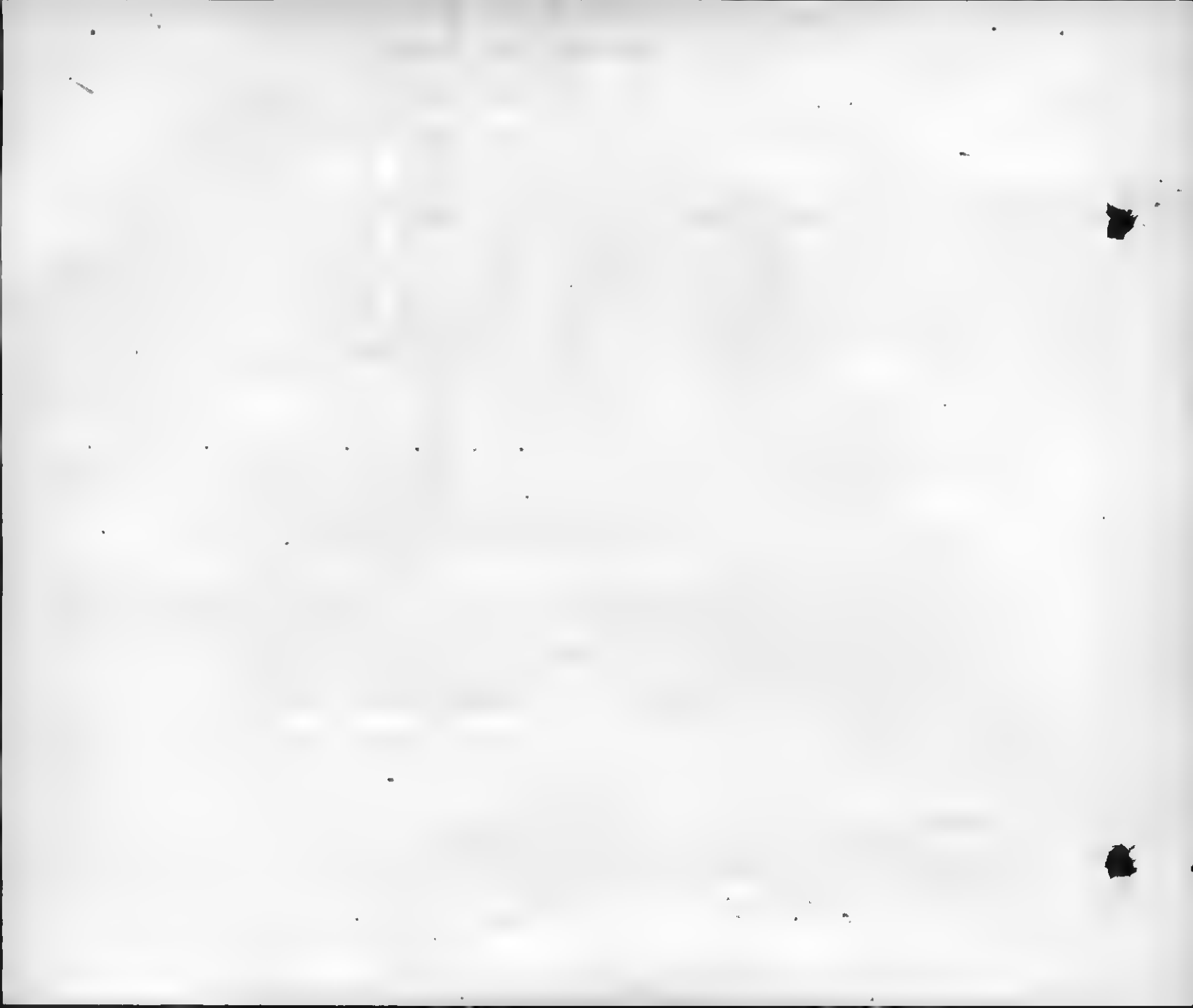
CERTIFICATE OF DEATH

06533

Reg. Dist. No.

| | | | |
|--|--|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 80 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| f. STREET ADDRESS 111 W. Mulberry Street | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle (NMI) Last JONES | | 4. DATE OF DEATH Month June Day 22 Year 19 58 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/17/87 |
| 9. AGE (In years last birthday) 70 yrs | IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min 70 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber | |
| 10a. KIND OF BUSINESS OR INDUSTRY Barber Shop | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13. FATHER'S NAME Patrick Jones | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Wormal | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes | |
| 16. SOCIAL SECURITY NO 578-01-1080 | | 17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PERFORATED URINARY BLADDER 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CA OF PROSTATE WITH METASTASIS TO URINARY BLADDER DUE TO AND BONES (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 2 PLUS YRS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Fort Howard, Maryland | | (County) (State) | |
| 21. I certify that I attended the deceased from April 3 , 19 58 , to June 22 , 19 58 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Chien Wei Lan | | DATE SIGNED 6/22/58 | |
| PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D. | | ADDRESS (Street, city or town, state) Fort Howard, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6-23-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc. | | 24a. REC'D BY REGISTRAR JUN 25 '58 | |
| 24b. REGISTRAR'S SIGNATURE Alf Search | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06534

6550

CERTIFICATE OF DEATH

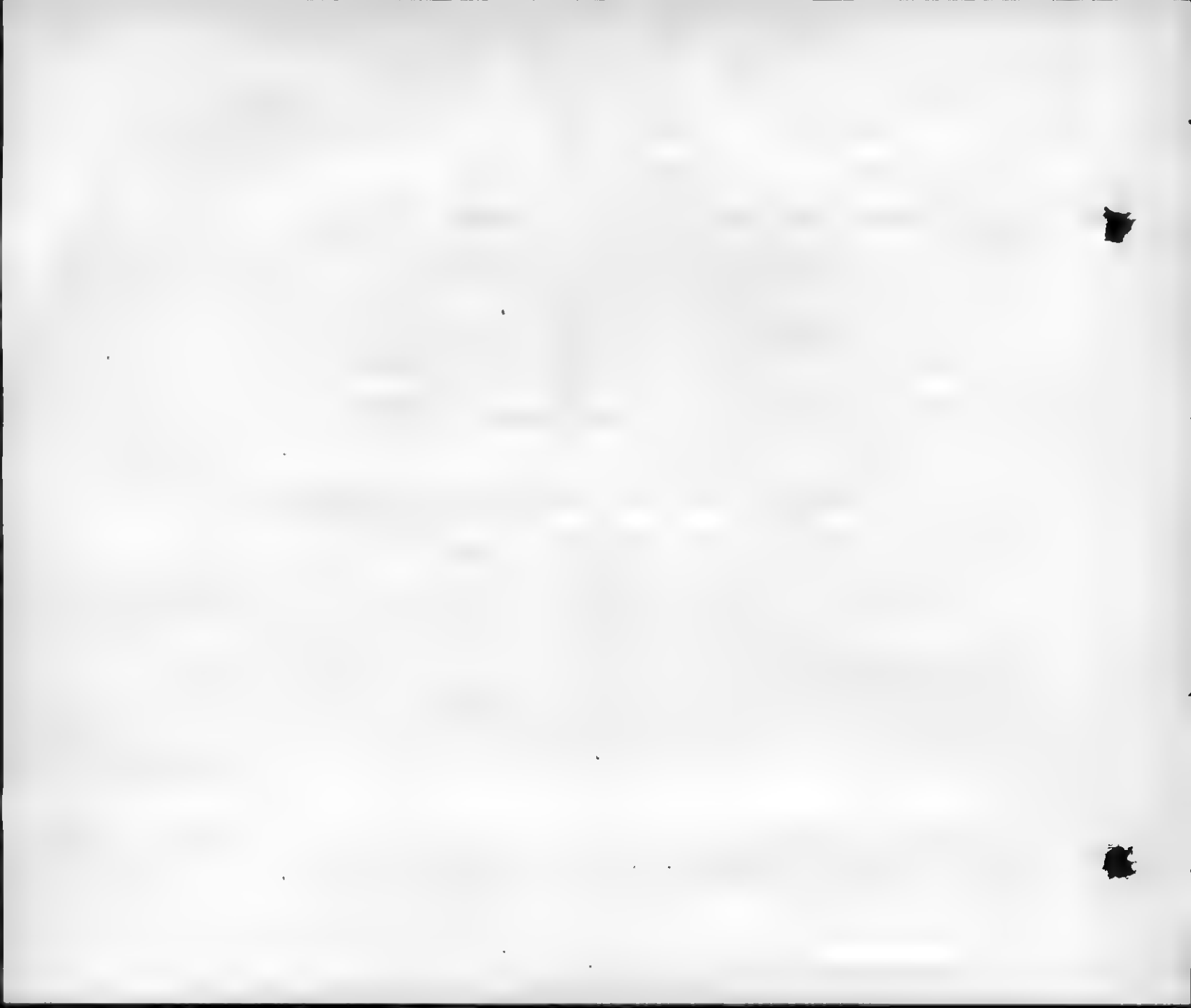
Reg. Dist. No.

| | | | |
|---|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1yr 9mths 14days X Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Ethel Last Justice | | 4. DATE OF DEATH Month June Day 26 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 23, 1893 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Hamilton Taylor | | 14. MOTHER'S MAIDEN NAME Mary Graham | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-24-3176 | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| (b) Generalized arteriosclerosis | | | |
| DUE TO | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| Cerebral vascular accident - old | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 7 , 19 57 , to June 26 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at 8:40a M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE Bruno Radauskas | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-26-58 | |
| PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D. | | Catonsville 28, Md. | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/28/1958 | 22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellesworth Armas Per P.H. King | | 24a. REC'D BY REGISTRAR DATE JUN 30 '58 | 24b. REGISTRAR'S SIGNATURE W. J. Smith |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

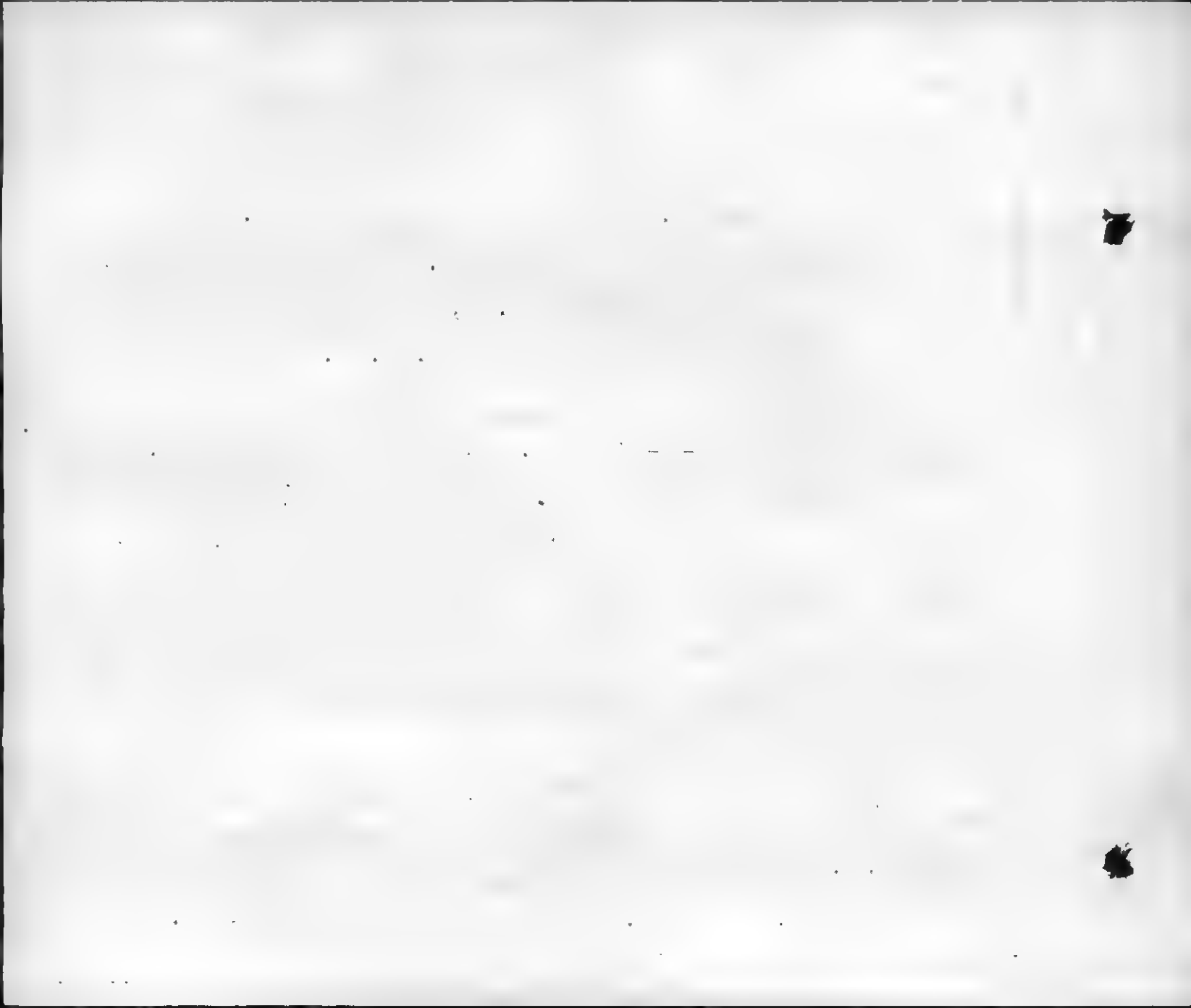
6551

CERTIFICATE OF DEATH

Reg. Dist. No. 06535

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 183 Forge Rd.</u> | | e. STREET ADDRESS <u>Box 183 Forge Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Kahl</u> Last <u>Jr.</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 25, 1887</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | 11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>George Kahl</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Furnkas</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>220-07-9131</u> | |
| 17. INFORMANT <u>Mrs. Barbara Kahl</u> | | Address <u>Box 183 Forge Rd. Fullerton</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>48 hrs.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Arterio Sclerotic Cardio Vascular disease</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify, that I attended the deceased from <u>12/1</u> , 19 <u>58</u> , to <u>6/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/14/58</u> , 19 <u>58</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>G. M. Baumgardner</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Baltimore Md.</u> <u>6/16/58</u> | |
| PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>June 18, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u> | 22d. LOCATION (City, town, or county) (State) <u>Fullerton, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Asscher Funeral Home</u> | | ADDRESS <u>7401 Belair Rd.</u> | |
| 24a. REC'D BY REGISTRAR <u>JUN 17 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

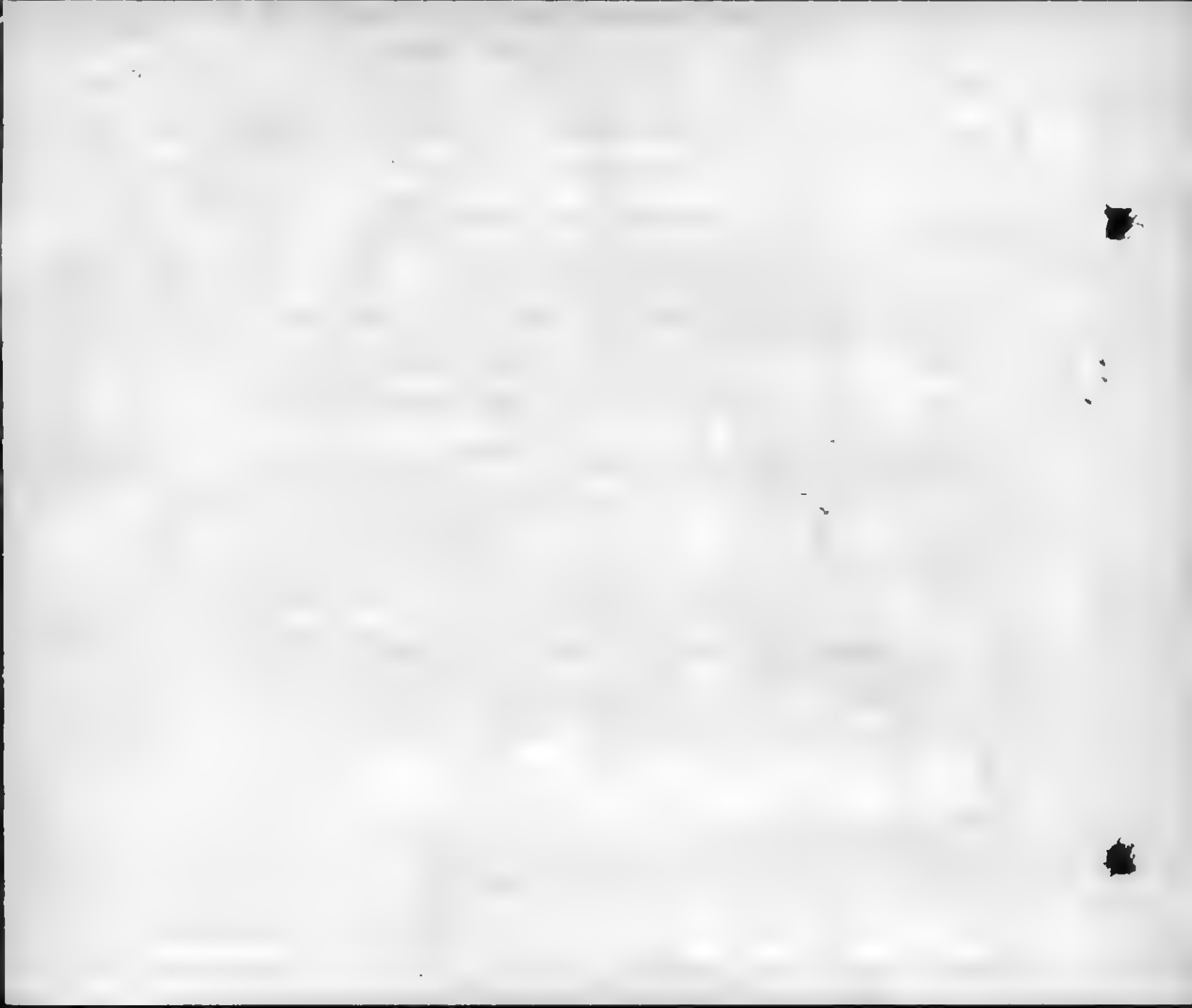
06536

6532

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE Co. Md</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-BAINSVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BAINSVILLE</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>8714 Eddington Road</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>KAIN</u> | | | | 4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1958</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN 17, 1884</u> | |
| 9. AGE (In years last birthday) <u>74</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S.</u> | |
| 13. FATHER'S NAME <u>John J. Killen</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JULIA COSICK</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NO</u> | | 17. INFORMANT <u>MRS MARIAN PIGNATARO</u> Address <u>8714 Eddington Rd</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accidents</u> DUE TO <u>Arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obstructed Arteries</u> DUE TO (c) <u>Obstructed Arteries</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u> <u>10 yrs</u> <u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>May 31, 1958</u> to <u>June 3, 1958</u> that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph F. Pira M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>8400 Rock Haven Blvd Baltimore Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH F. PIRA M.D.</u> | | | | DATE SIGNED <u> </u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>JUNE 7 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rita Wiedefeld</u> | | | | ADDRESS <u>900 E. Biddle St</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 5 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u> </u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

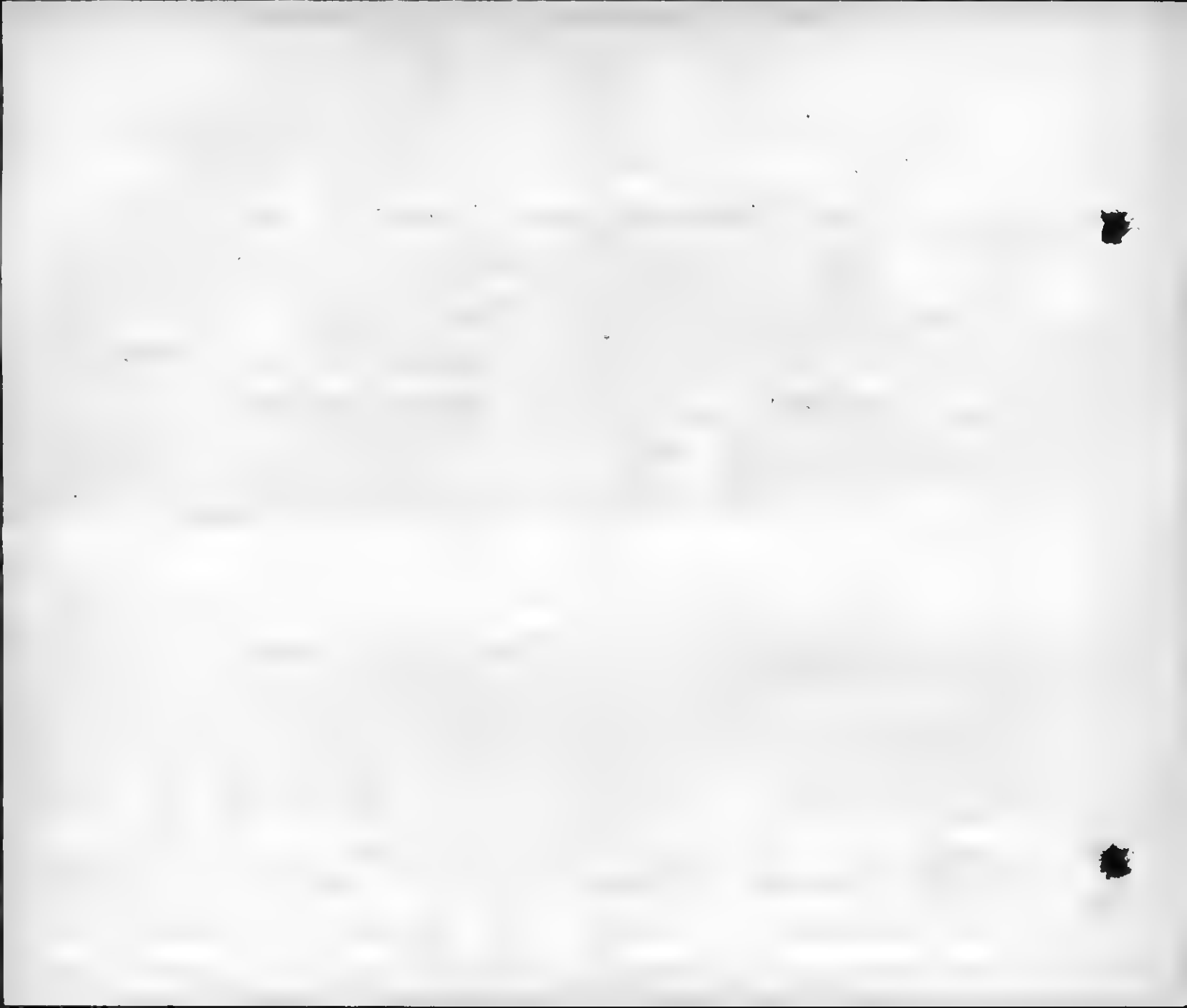
6553

CERTIFICATE OF DEATH

06537

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Goldenhiel</u> | | | |
| c. LENGTH OF STAY in 1b <u>3 years</u> | | | | d. STREET ADDRESS <u>3104 Cedar Hurst Road</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>Cecilia</u> Last <u>Keene</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>19 58</u> | | | | |
| 5 SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/24/1870</u> | 9. AGE (In years last birthday) <u>88</u> yrs. | IF UNDER 1 YEAR: Months <u>18</u> Days <u>19</u> Hours <u>58</u> Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>America</u> | | | | | | | |
| 13. FATHER'S NAME <u>Samuel Keene</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eleanora Applegarth</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Stella Maris Spence</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Arteriosclerotic degenerative C.V. Disease</u> DUE TO <u>auricular fibrillation. Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Terminal Anemia</u> DUE TO <u>Senility</u> (c) <u>Senility</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1955</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>4 Nov. 1955</u> to <u>18 June 1958</u> , that I last saw the deceased alive on <u>18 June 1958</u> , and that death occurred at <u>8:05 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph E. Muse Jr.</u> M.D. <u>2725 N. Charles St.</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH E. MUSE JR. M.D. Baltimore 18, Md</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-20-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Bald. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. ...</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>JUN 3 58</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>...</u> | |



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06538

CERTIFICATE OF DEATH

6480

Reg. Dist. No.

| | | | | | | | |
|---|------------------|--|----------------------|---|-----------------|---|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>BALTIMORE</u> | | STATE <u>Md</u> | | COUNTY <u>BALTIMORE</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>HALETHORPE</u> | | <u>20 yrs.</u> | | TOWN <u>HALETHORPE</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5633 Ashbourne Rd</u> | | | | STREET ADDRESS (If rural give location) <u>5633 Ashbourne Rd</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>John</u> (Middle) <u>ALBERT</u> (Last) <u>KELLY</u> | | | | (Month) <u>JUNE</u> (Day) <u>29</u> (Year) <u>1958</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>MALE</u> | <u>WHITE</u> | <u>MARRIED</u> | <u>NOV. 28, 1894</u> | <u>63</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>MACHINIST</u> | | <u>INDUSTRIAL</u> | | <u>MARYLAND</u> | | <u>U.S.A</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MARIEN NAME | | | |
| <u>Edward M. KELLY</u> | | | | <u>UNKNOWN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>YES</u> | | <u>WORLD WAR I</u> | | <u>215-03-3085</u> | | <u>ELIZABETH KELLY 5633 Ashbourne Rd</u> | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| <u>Adenocarcinoma Stomach</u> | | | | <u>7 mos</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE | | | | <u>Adenocarcinoma descending Colon 1 mo</u> | | | |
| STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | | |
| <u>6-23-57</u> | | <u>Adenocarcinoma, Stomach, Colon</u> | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>OCT 57</u> , 19 <u>57</u> , to <u>JUNE 29, 1958</u> , that I last saw the deceased alive on <u>JUNE 28, 1958</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | | |
| <u>A. Bradley Laughlin</u> | | <u>1204 1/2 ...</u> | | <u>6308</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>7-2-58</u> | | <u>BALTIMORE NATIONAL</u> | | <u>BALTIMORE Md</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>JUL 1</u> | | <u>[Signature]</u> | | <u>GEORGE L. SCHWAB FUNERAL HOME</u> | | <u>Barbara M. Schuch 2101 Frederick Ave</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

AISC 1-55 10M



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06539

6554

| | | | | | | | |
|--|---------------------------|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora Marie King</u> | | | | 4. DATE OF DEATH Month Day Year <u>6 - 23 - 1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-25-1890</u> | | 9. AGE (In years last birthday) <u>67</u> yrs | 10. IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>Benjamin Wood</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Bowen</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>Mrs. A. Harbaugh 3513 Shred St.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350x Acute Cardiac Failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Paralysis Aptonia</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 years</u> <u>5 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Jan 1, 1958</u> to <u>June 24, 1958</u> that I last saw the deceased alive on <u>6-24, 1958</u> and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE <u>Louis J. Glass</u> M.D. | | | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>Louis J. Glass</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-26-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Mc Cully Funeral Home 130 E. Fort Ave</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

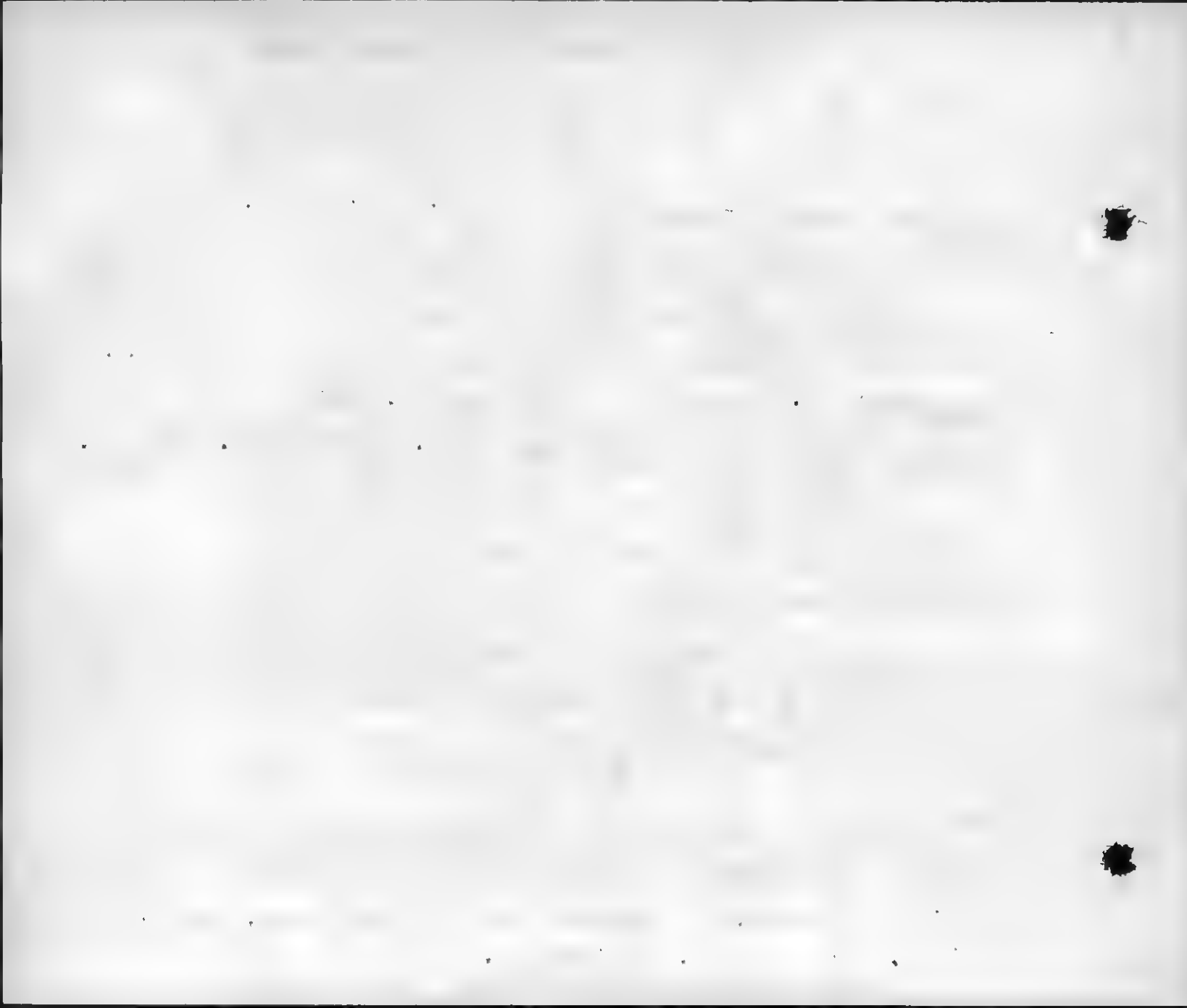
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06540

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|---|---|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital | | | | d. STREET ADDRESS 415 N. East Ave., Balto. #24 Md | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ALBERT Middle EDWARD Last KLEIN | | | | 4. DATE OF DEATH Month 6 Day 10 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-22-09 | | 9. AGE (In years last birthday) 49 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Plant | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward W. Klein | | | | 14. MOTHER'S MAIDEN NAME Mamie K. Davis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 216-14-0835 | | 17. INFORMANT Address Mrs Anna M. Klein 415 N. East Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Time | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE M.B. Davis M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) M.B. Davis M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 14, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran 3000 E. Baltimore St. | | | | 24a. REC'D BY REGISTRAR JUN 16 '58 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



6556

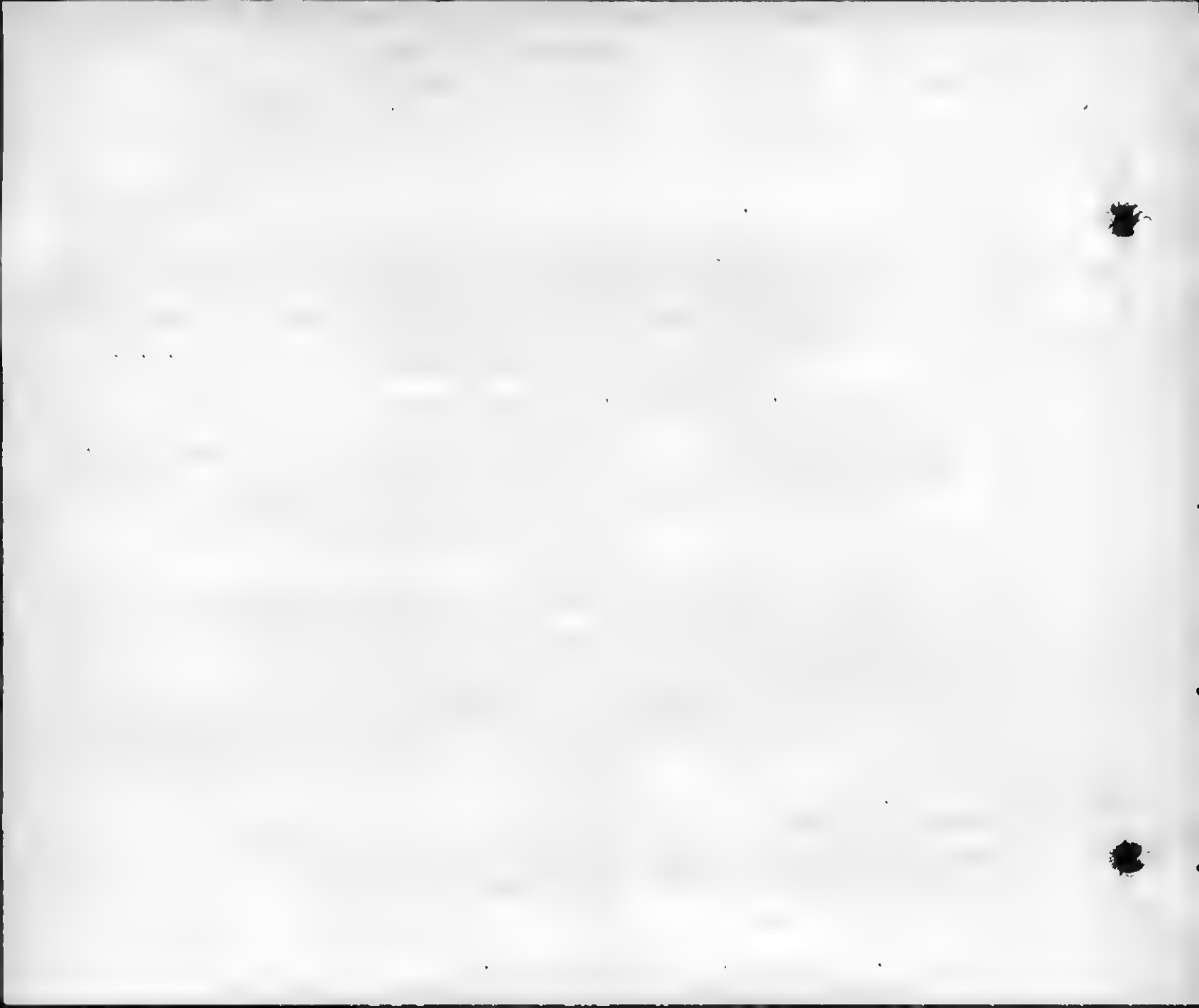
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3915 Overlea Ave.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Frederick W. Koenig, Jr.</i> | | 4. DATE OF DEATH Month Day Year <i>June 16, 1958</i> | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>July 24, 1883</i> |
| 9. AGE (In years last birthday) <i>74</i> yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Druggist</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Fredrick W. Koenig, Sr.</i> | | 14. MOTHER'S MAIDEN NAME <i>Amelia Burke</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT <i>Valeria R. Koenig</i> | | Address <i>3915 Overlea Ave.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis with left</i> | | | |
| DUE TO (b) <i>hemiparesis; Generalized arteriosclerosis</i> | | | |
| DUE TO (c) <i>Aneurysm abdominal aorta, directing (not known)</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>57</i> , to <i>16 June</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>14 June</i> , 19 <i>58</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <i>Charles M. Kerr</i> M.D. | | ADDRESS (Street, city or town, state) <i>6801 Belair Rd Baltimore, Md.</i> | |
| PHYSICIAN'S NAME (Type) <i>Charles M. Kerr</i> | | DATE SIGNED <i>June 16, 58</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>6/19/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i> | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>5305 Harford Rd.</i> | |
| 24a. REC'D BY REGISTRAR <i>DATE JUN 20 '58</i> | | 24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6557

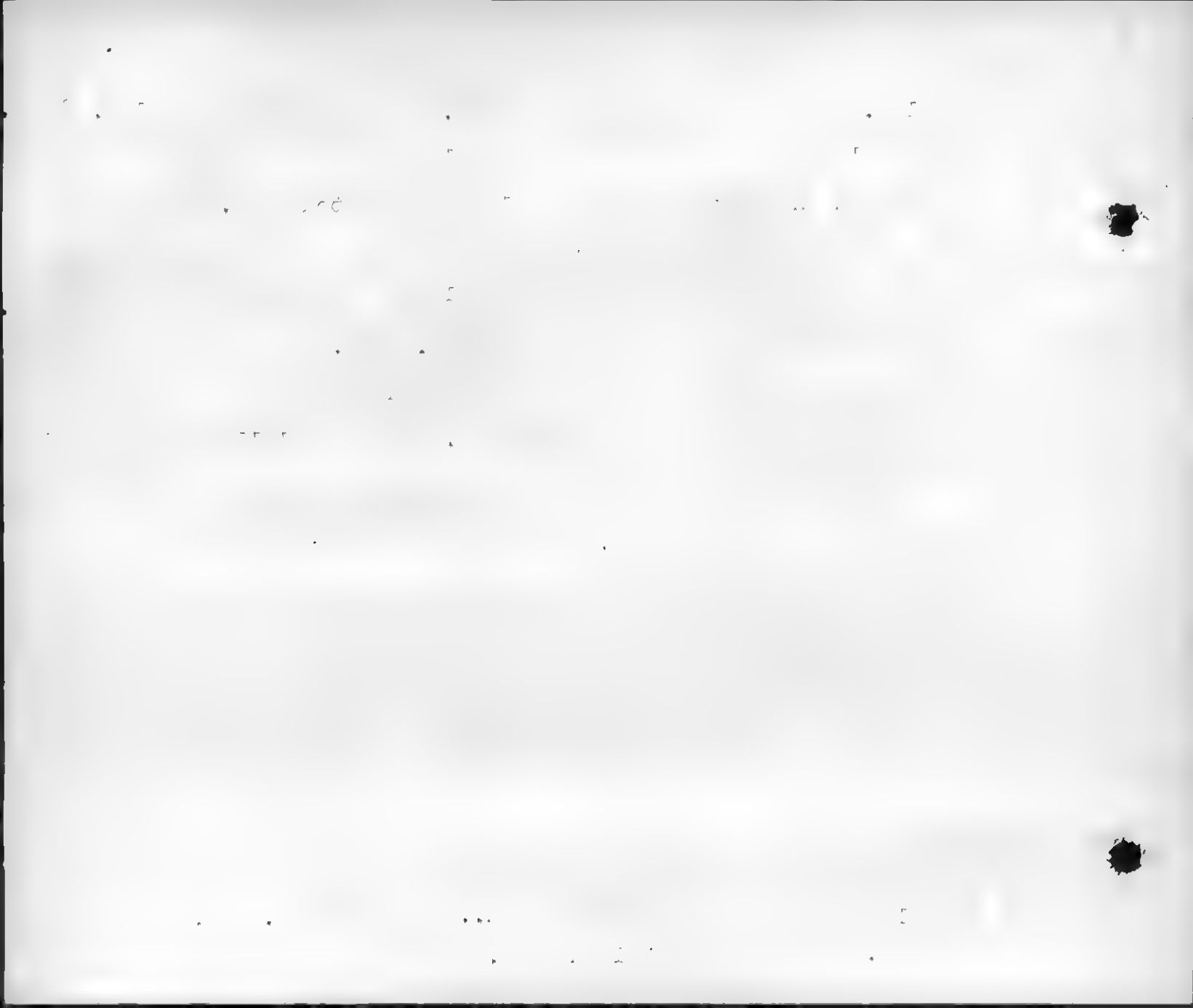
CERTIFICATE OF DEATH

Reg. Dist. No.

06542

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines | | d. STREET ADDRESS 1231 Washington Blvd. | |
| 3. NAME OF DECEASED (Type or print) Elizabeth Marie Kostusch First Middle Last | | 4. DATE OF DEATH 6-22-58 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-11-1892 |
| 9. AGE (In years last birthday) 66 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Louis Lees | | 14. MOTHER'S MAIDEN NAME Johannah | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Carlyn E. Kostusch | | Address 1231 Washington Blvd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, right 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular System DUE TO Disease (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 2-9 , 19 57 , to 6-22 , 19 58 , that I last saw the deceased alive on 6-16 , 19 58 , and that death occurred on 6-22 , 19 58 , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John P. Welch Jr. M.D. | | ADDRESS (Street, city or town, state) 1227 Wash. Blvd. Baltimore | |
| PHYSICIAN'S NAME (Type) | | DATE SIGNED 6/23/58 | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-5-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. | |
| 24a. REC'D BY REGISTRAR JUN 25 '58 | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6558

CERTIFICATE OF DEATH

Reg. Dist. No. 06543

| | | | |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b <u>52</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1912 Altavue Road</u> | | e. STREET ADDRESS <u>1912 Altavue Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u></u> Last <u>Krause</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 15, 1877</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Bohemia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>Mrs. Marie K. Smith, 1912 Altavus Road</u> | | Address <u>ZONE 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive arteriosclerotic</u> cause (c) <u>cardiovascular disease</u> lying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>several yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>15 June, 1958</u> to <u>15 June, 1958</u> that I last saw the deceased alive on <u>15 June, 1958</u> and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James E. Rowe</u> M.D. | | ADDRESS (Street, city or town, state) <u>715 FREDERICK RD</u> DATE SIGNED <u>6/18/58</u> | |
| PHYSICIAN'S NAME (Type) <u>James E. Rowe, M.D.</u> | | <u>BALTO 28. MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>16-18-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> | | 24a. REC'D BY REGISTRAR <u>JUN 19 58</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>Overman</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06544

Item 3 Film G231 7/24/58 GLE

Reg. Dist. No.

FOR STATE HEALTH DEPT.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Philadelphia Rd. & Kenwood Avenue | | d. STREET ADDRESS 7429 Brookwood Road | |
| 3. NAME OF DECEASED (Type or print) Henry First JOHN Middle (Kritz) Last HAITZ | | 4. DATE OF DEATH Month June Day 13 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-11-1905 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Motors, | | 9b. KIND OF BUSINESS OR INDUSTRY Clerk | |
| 10. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 11. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-10-4526 | |
| 17. INFORMANT Mrs. Edna C. Kritz | | Address 7429 Brookwood Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease. 44-16 DUE TO Conditions, if any, which gave rise to immediate cause (b) ? (c), stating the underlying cause lost. (c) ? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Paul F. Guerin | | DATE SIGNED 6/13/58 | |
| EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6/16/58 | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck | | 24. REGISTRAR'S SIGNATURE W. J. Ruck | |
| ADDRESS 5305 Harford Road #14 | | DATE JUN 17 '58 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6560

CERTIFICATE OF DEATH

06545

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Baltimore | | MARYLAND | | STATE Md. | | COUNTY Balto. | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWSON | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 8110 Clyde Bank Rd. | | | | STREET ADDRESS (If rural give location) 8110 Clyde Bank Rd. | | | |
| 3. NAME OF DECEASED (Type or Print) Katie Lang | | | | 4. DATE OF DEATH (Month) (Day) (Year) June 24, 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH June 10, 1876 | |
| 9. AGE last birthday 82 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Broeker | | | | 14. MOTHER'S MAIDEN NAME Minnie ?? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Jacob Lang 8110 Clyde Bank Rd. | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) Coronary Occlusion | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) Arterio-Sclerotic Heart Disease | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> No 1 while at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from 2-10-55 , to 6-24-58 , that I last saw the deceased alive on 6-24-58 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Dr. Lee R. Fargo | | | | DATE SIGNED 3-24-58 | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) burial | | DATE THEREOF June 27, 1958 | | NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | LOCATION (City, town, or county) (State) Balto. Co. Md. | |
| 24. REC'D BY REGISTRAR DATE JUN 30 '58 | | REGISTRAR'S SIGNATURE Olden | | 25. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Baltimore, Md. | | | |

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be examined within 24 hours after death. The body may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC T-55 10M.



TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6561 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06548

Reg. Dist. No.

| | | | | | | | |
|---|--|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balt.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | c. LENGTH OF STAY IN 1b <u>3-4 yr</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Benson Mill Rd</u> | | | | d. STREET ADDRESS <u>Benson Mill Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>HARRY SYLVESTER LEZER</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 29, 1900</u> | | 9. AGE (In years last birthday) <u>58</u> yrs. | IF UNDER 1 YEAR Months <u></u> Days <u></u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Chas. Lezer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Lucy Gentler</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-32-0112</u> | | 17. INFORMANT <u>Elmer Lezer, Hagerstown, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot on road in back of head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Secured</u> (a), stating the underlying cause last. DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Shot on road in back of head</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>4 PM</u> o. m. <u></u> <u>June 2 1958</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <u>Highway</u> | | 20f. (City or town) <u>Hagerstown</u> | | (County) <u>Washington</u> (State) <u>Pa.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>J. F. Eline</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>6-2-58</u> | |
| EXAMINER'S NAME (Type) <u>J. F. Eline, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>June 5/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Salem Union</u> | | 22d. LOCATION (City, town, or county) (State) <u>Jacobus, York County, Pa.</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F.Eline & Sons, Reisterstown, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>June 4 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Ed. Leach</u> | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

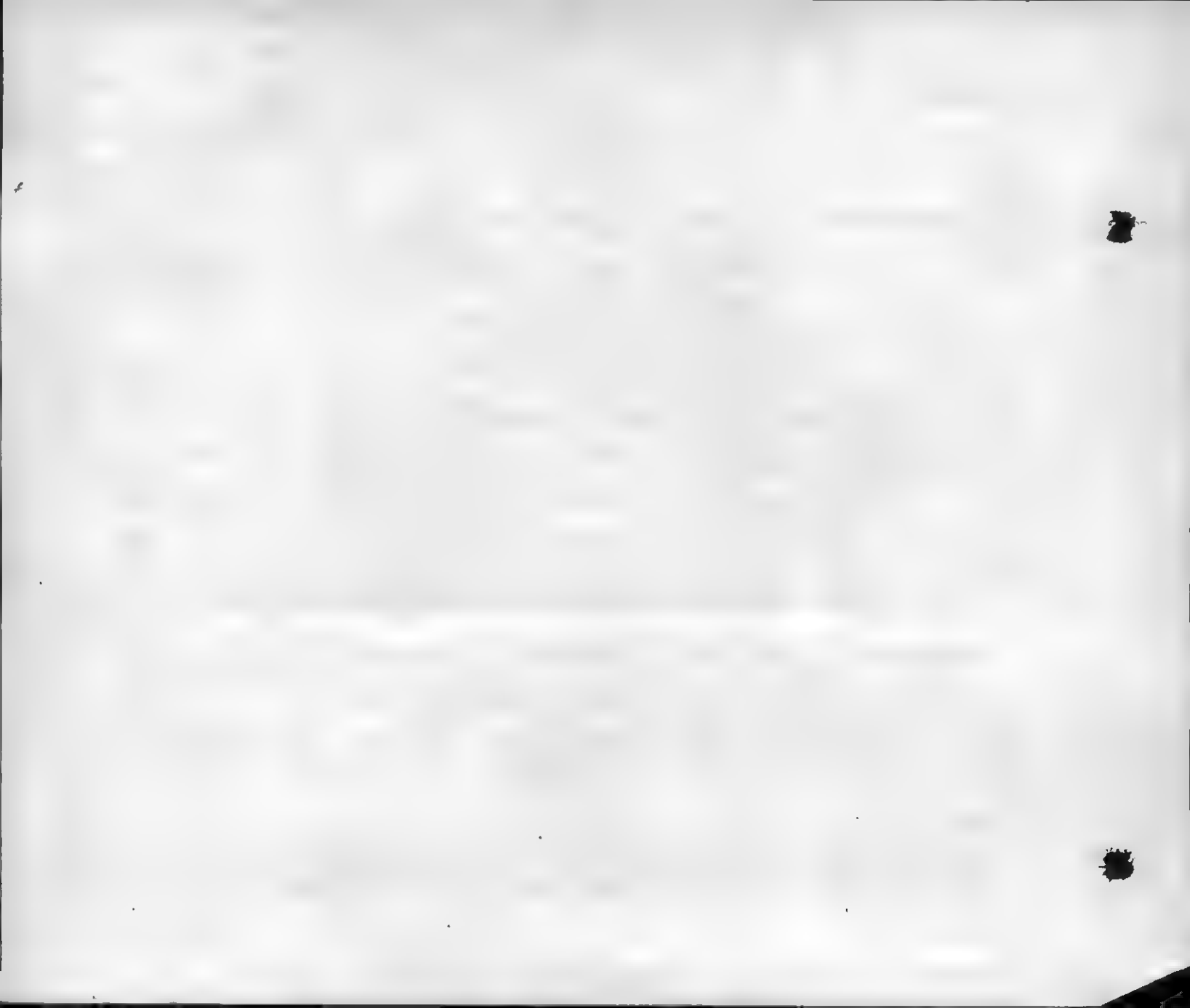
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6562 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06547

Reg. Dist. No.

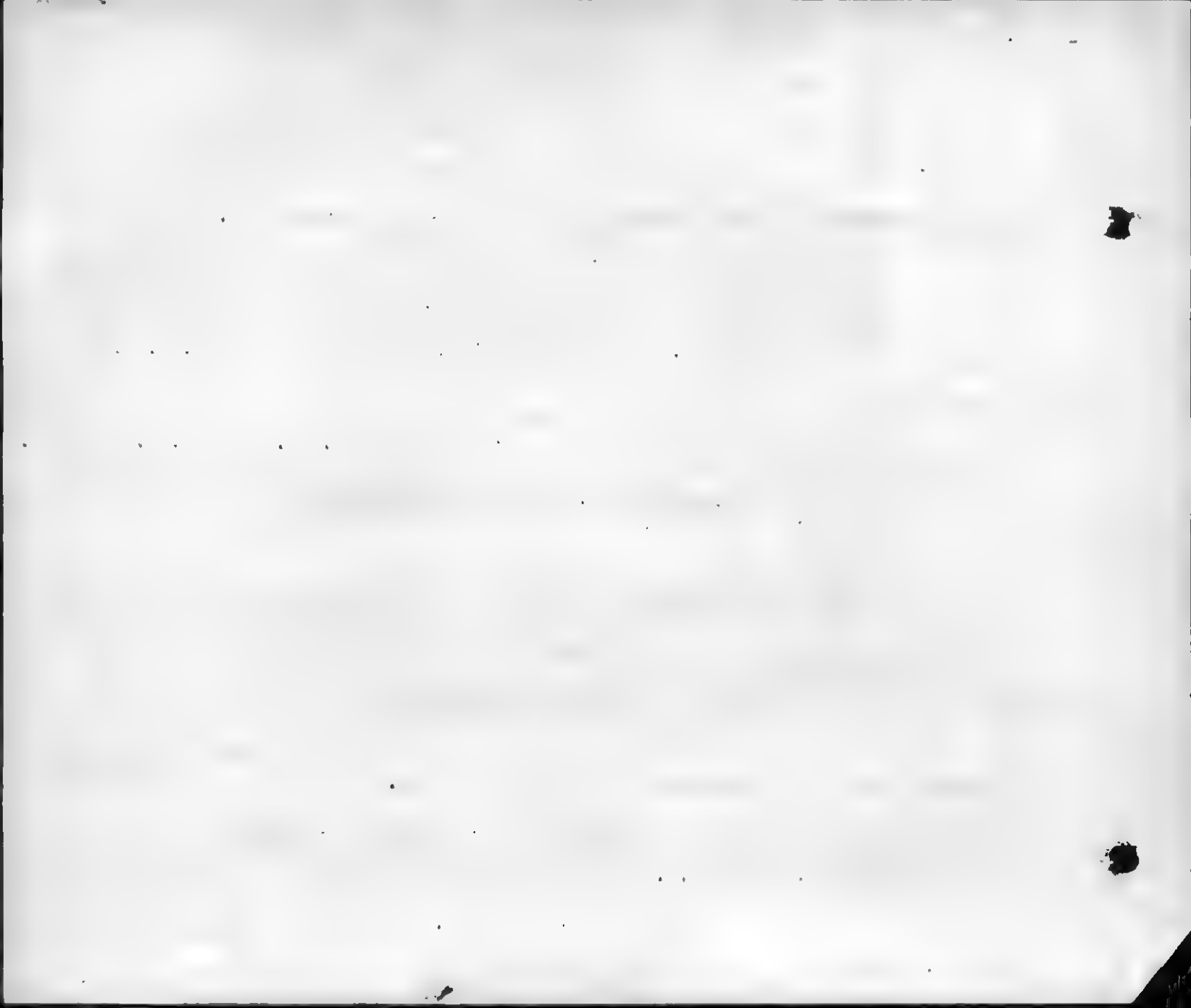
| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. WILSON P.O. | | c. LENGTH OF STAY IN 1b 18 HRS. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MT. WILSON | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle Last LEE | | 4. DATE OF DEATH Month JUNE Day 28 Year 1958 | |
| 5. SEX MALE | 6. COLOR OR RACE CHINESE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 5, 1896 |
| 9. AGE (in years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRY WORKER | | 10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY | 11. BIRTHPLACE (State or foreign country) CHINA |
| 12. CITIZEN OF WHAT COUNTRY? Unknown | | 13. FATHER'S NAME CHEE TAI LEE | |
| 14. MOTHER'S MAIDEN NAME CHIU SHEE | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | |
| 16. SOCIAL SECURITY NO 219-32-0720 | | 17. INFORMANT CART MT. WILSON HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) COR PUMMONALE DUE TO (c) PULMONARY TUBERCULOSIS | | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 6 WKS. AT LEAST 44RS. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE Martin E. Strobel | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) MARTIN E. STROBEL | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> FOR D.D. CAPLES | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial June 30 | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY Lorraine | | 22d. LOCATION (City, town, or county) (State) Brooklyn | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Sheldon Moxley | | ADDRESS 105 W York Baltimore | |
| 24a. REC'D BY REGISTRAR DATE JUN 30 '58 | | 24b. REGISTRAR'S SIGNATURE W. Search | |



06548

MEDICAL CERTIFICATION

(4)
3/57



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6564 CERTIFICATE OF DEATH

00549

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|--|---|--|---|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Baltimore | | MARYLAND | | STATE Maryland | | COUNTY | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Essex | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Essex | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 511 Myrth Ave. | | | | STREET ADDRESS (If rural give location) 511 Myrth Ave. | | | |
| 3. NAME OF DECEASED (Type or Print) EUGENE L. LINDSAY | | | | 4. DATE OF DEATH (Month) (Day) (Year) June 9, 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Sept. 17, 1900 | 9. AGE last birthday 57 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing inspector | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Melvin Lindsay | | | | 14. MOTHER'S MAIDEN NAME Annie Ruff | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No. | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Mrs. Elizabeth Lindsay 511 Myrth Ave. | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 416X IMMEDIATE CAUSE (A) Coronary occlusion | | | | | | 2 days | |
| ANTECEDENT CAUSE(S) DUE TO (B) Rheumatic Heart | | | | | | 3 yrs | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Recurrent Embolic Phenomena | | | | | | 3 yrs | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21e. INJURY OCCURRED | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from June 8, 19 58, to June 9, 19 58, that I last saw the deceased alive on June 9, 19 58, and that death occurred at 10 P. M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE M. Barmgardner M.D. | | | | ADDRESS (Street, city, town, state) Balto 6 Md | | DATE SIGNED 6/11/58 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF June 13, 1958 | | NAME OF CEMETERY OR CREMATORY Zion Evan Lutheran | | LOCATION (City, town, or county) Stemmers Run, Md. | |
| 24. REC'D BY REGISTRAR DATE JUN 10 58 | | REGISTRAR'S SIGNATURE [Signature] | | 25. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road. | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

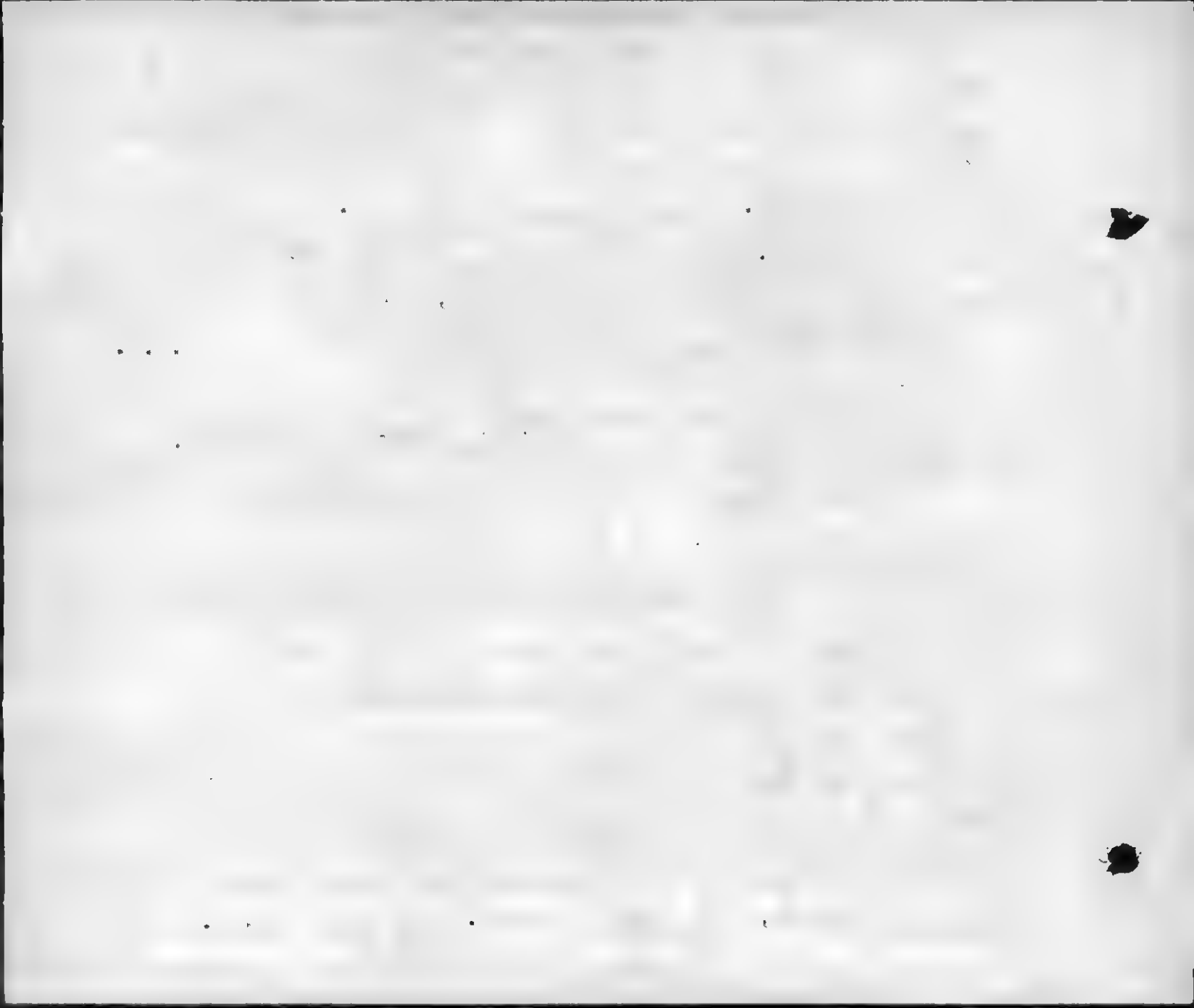
VS A15C 1-55 10M



6565

N

IVS A15 (4)
15M 9/SS





1

VS A15ME
5M 2.57

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> | | b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> | | c. LENGTH OF STAY IN 1b <u>15 MO.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 DUNDALK</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DUNDALK TRAILER PK - STANBURY Rd</u> | | d. STREET ADDRESS <u>DUNDALK TRAILER PK - STANBURY Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>ONIL</u> | | First <u>ONIL</u> Middle <u>LIVERMOCH</u> Last <u>LIVERMOCH</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1958</u> | |
| 5. SEX <u>M.</u> | | 6. COLOR OR RACE <u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>2 SEPT. 1926</u> | | 9. AGE (in years last birthday) <u>31</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u> | | 12. KIND OF BUSINESS OR INDUSTRY <u>GENERAL CONSTRUCTION</u> | | 13. BIRTHPLACE (State or foreign country) <u>CANADA</u> | |
| 14. CITIZEN OF WHAT COUNTRY? <u>CANADA</u> | | 15. FATHER'S NAME <u>EMERY LIVERMOCH</u> | | 16. MOTHER'S MAIDEN NAME <u>ALEXANDRINE BLAIS</u> | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 18. SOCIAL SECURITY NO <u>502 72-9148</u> | | 19. INFORMANT <u>CLERINE LIVERMOCH</u> Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | |
| 20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>William J. Smith</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>6-15-58</u> | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) <u>REMOVAL</u> | | 22b. DATE THEREOF <u>6/15/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>CAP de la MADELINE</u> | |
| 22d. LOCATION (City, town, or county) <u>CAP de la MADELINE</u> | | 22e. REC'D BY REGISTRAR <u> </u> | | 22f. REGISTRAR'S SIGNATURE <u> </u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> | | ADDRESS <u> </u> | | DATE <u>JUN 18 '58</u> | |



6566

CERTIFICATE OF DEATH

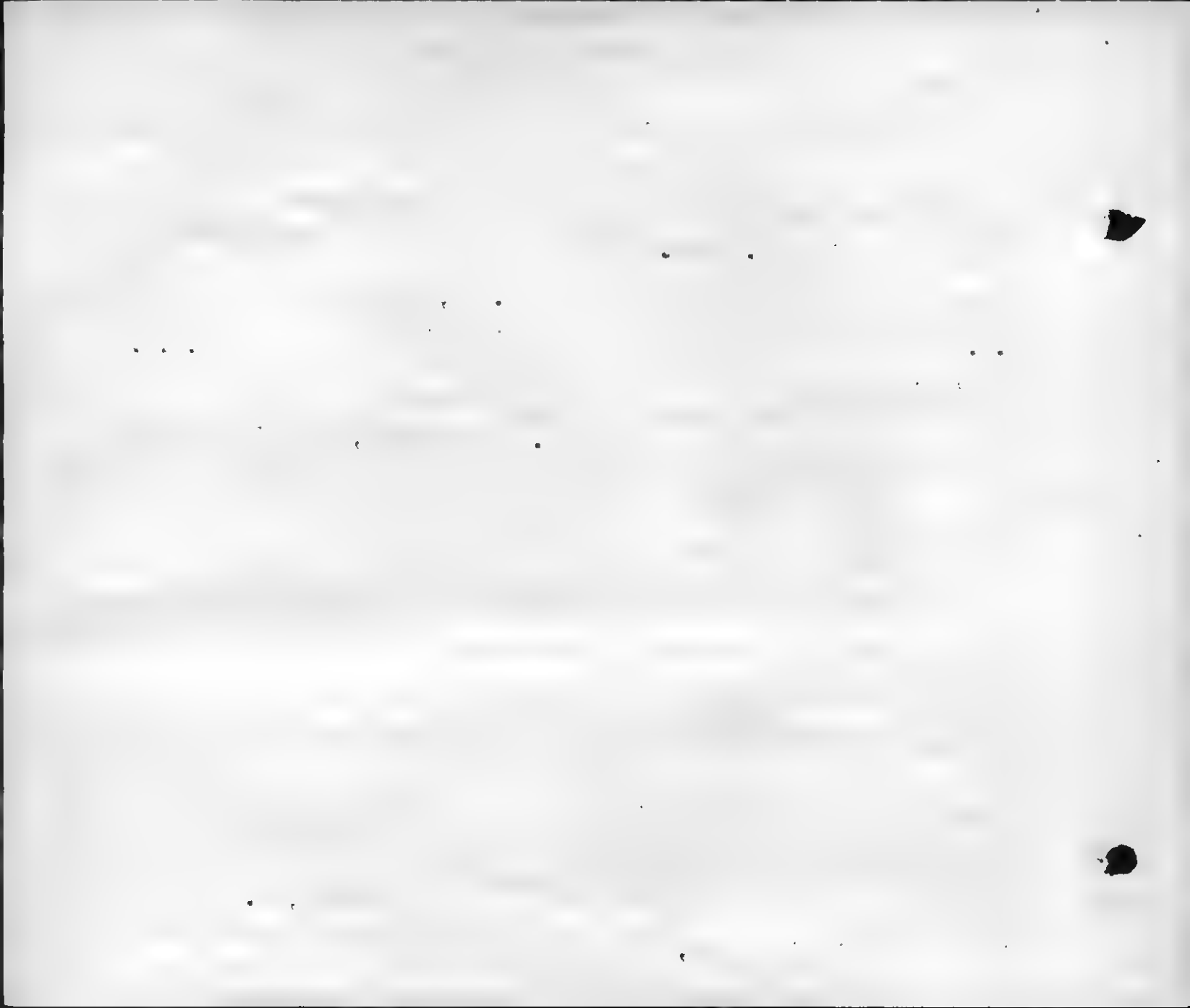
Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7716 Liberty Road | | d. STREET ADDRESS 7716 Liberty Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Alice M. von Lossberg | | 4. DATE OF DEATH Month Day Year June 3/58 19 | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 19, 1874 |
| 9. AGE (In years last birthday) 84 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Virginia |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME William Doggett | | 14. MOTHER'S MAIDEN NAME Sue Emma | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Henry Wagner, 7716 Liberty Road | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONG. HEART FAILURE - RENAL 4. DUE TO FAILURE & PULMONARY EDEMA - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) HYPERTENSIVE C.V. DISEASE & CHRONIC (c) Heart Failure INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 5 YEARS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from MAR 1 19 58 , to JUNE 3 19 58 , that I last saw the deceased alive on JUNE 3 19 58 , and that death occurred at 6 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3601 Clapnet Rd - 7 - 4/4/58 DATE SIGNED ACTUAL SIGNATURE Thomas E. Wheeler M.D. PHYSICIAN'S NAME (Type) THOMAS E. WHEELER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 6/58 | 22c. NAME OF CEMETERY OR CREMATORY Meadowridge | 22d. LOCATION (City, town, or county) (State) Bersey, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Fitzke Funeral Directors, 4101 Edmondson | | 24a. REC'D BY REGISTRAR DATE June 6 58 | 24. REGISTRAR'S SIGNATURE W. E. ... |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06553

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore POINT | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPARRO'S POINT HOSPITAL | | | | d. STREET ADDRESS 5204 Midwood Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Vance LOVE | | | | 4. DATE OF DEATH Month Day Year 6 13 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-1-1903 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger | | | | 10b. KIND OF BUSINESS OR INDUSTRY Ship Repair | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13. FATHER'S NAME VERNON KIBLER | | | |
| 14. MOTHER'S MAIDEN NAME MARY HOLLOWAY | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. 131-01-4982 | | | | 17. INFORMANT Address MRS. BARBARA LOVE 5204 MIDWOOD AVE BALTO. MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Occlusion 4x10.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last, DUE TO _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2x10.1 Diabetes Mellitus | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | | | |
| ACTUAL SIGNATURE Spill Collins | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Sack & Collins | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED 6-13-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/16/1958 | | 22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery | | 22d. LOCATION (City, town, or county) (State) Federalsburg MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Glenn F. Seitz | | | | ADDRESS 5209 York Rd. Balto. Md. | | | |
| 24a. REC'D BY REGISTRAR DATE JUN 17 '58 | | | | 24b. REGISTRAR'S SIGNATURE W. L. Lewis | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6568

CERTIFICATE OF DEATH

Reg. Dist. No. 06554

| | | | | | | | |
|--|---------------------------|---|-------------------------------------|---|--|--|---------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 12 | | | | c. LENGTH OF STAY IN lb 6 MOS. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1418 SHEFFORD ROAD | | | | e. STREET ADDRESS 1418 SHEFFORD ROAD | | | |
| 3. NAME OF DECEASED (Type or print) MILDRED M. LUETTE | | | | 4. DATE OF DEATH JUNE 25, 1958 19 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 2, 1918 | 9. AGE (In years last birthday) 40 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME RAYMOND ARMIGER | | | | 14. MOTHER'S MAIDEN NAME CHRISTINE MOESER | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO | | 16. SOCIAL SECURITY NO. 215 05 3505 | | 17. INFORMANT MR GILBERT C. LUETTE | | Address SAME | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr. | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 1939 to 6-25 , 1958 , that I last saw the deceased alive on 6-25 , 1958 , and that death occurred at 9:10 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE A. L. Ewald Jr. M.D. | | | | ADDRESS (Street, city or town, state) 36 York Court - 318 | | | |
| DATE SIGNED | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/28/58 | | 22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | | 22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC ADDRESS BALTIMORE MD. | | | | 24a. REC'D BY REGISTRAR DATE JUN 27 '58 | | 24b. REGISTRAR'S SIGNATURE Alb. [Signature] | |



6569

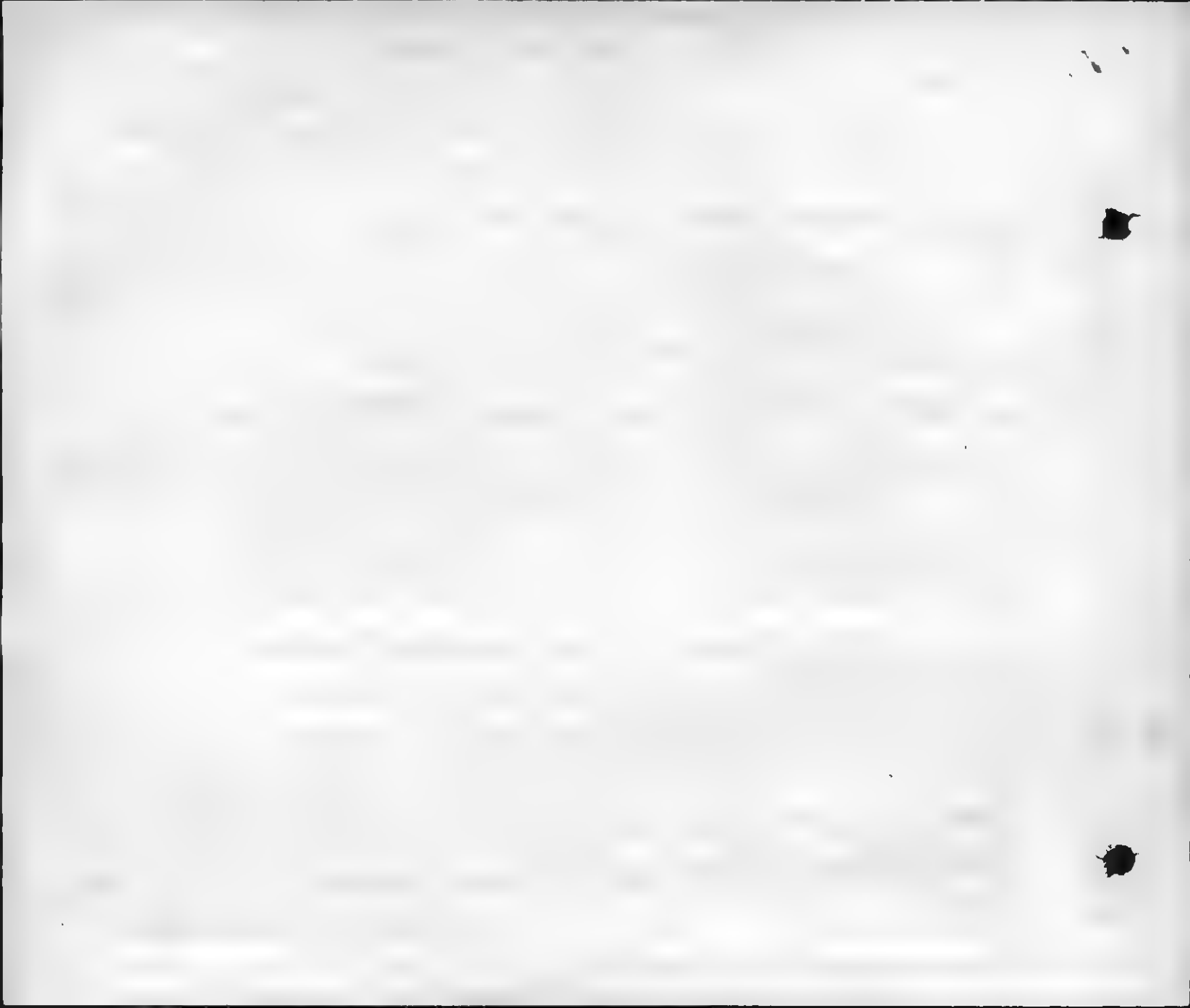
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9216 Carlisle Ave.</u> | | | | d. STREET ADDRESS <u>9216 Carlisle Balto 6</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William James Lutts</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 5 1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 3 - 1904</u> | 9. AGE (In years last birthday) yrs <u>53</u> | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Head Custodian</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md. State Penitentiary</u> | | 11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>William J. Lutts</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Gedonia Cook</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-36-2338</u> | | 17. INFORMANT Address <u>Mrs. Gertrude Lutts (wife) 2000</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchogenic Carcinoma with</u> DUE TO (c) <u>Brain metastasis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Surgical biopsy, exploratory Sept 25, 57)</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>5 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 June</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>John C. Hyle</u> | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>7527 Belair Rd Balto 6 6-5-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-7-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan, Lutheran</u> | | 22d. LOCATION (City, town, or county) (State) <u>Golden Ring Rd. Balto, Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Deed Smith</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the attending physician or completely filled by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 Maryland State Department of Health—Baltimore, 18

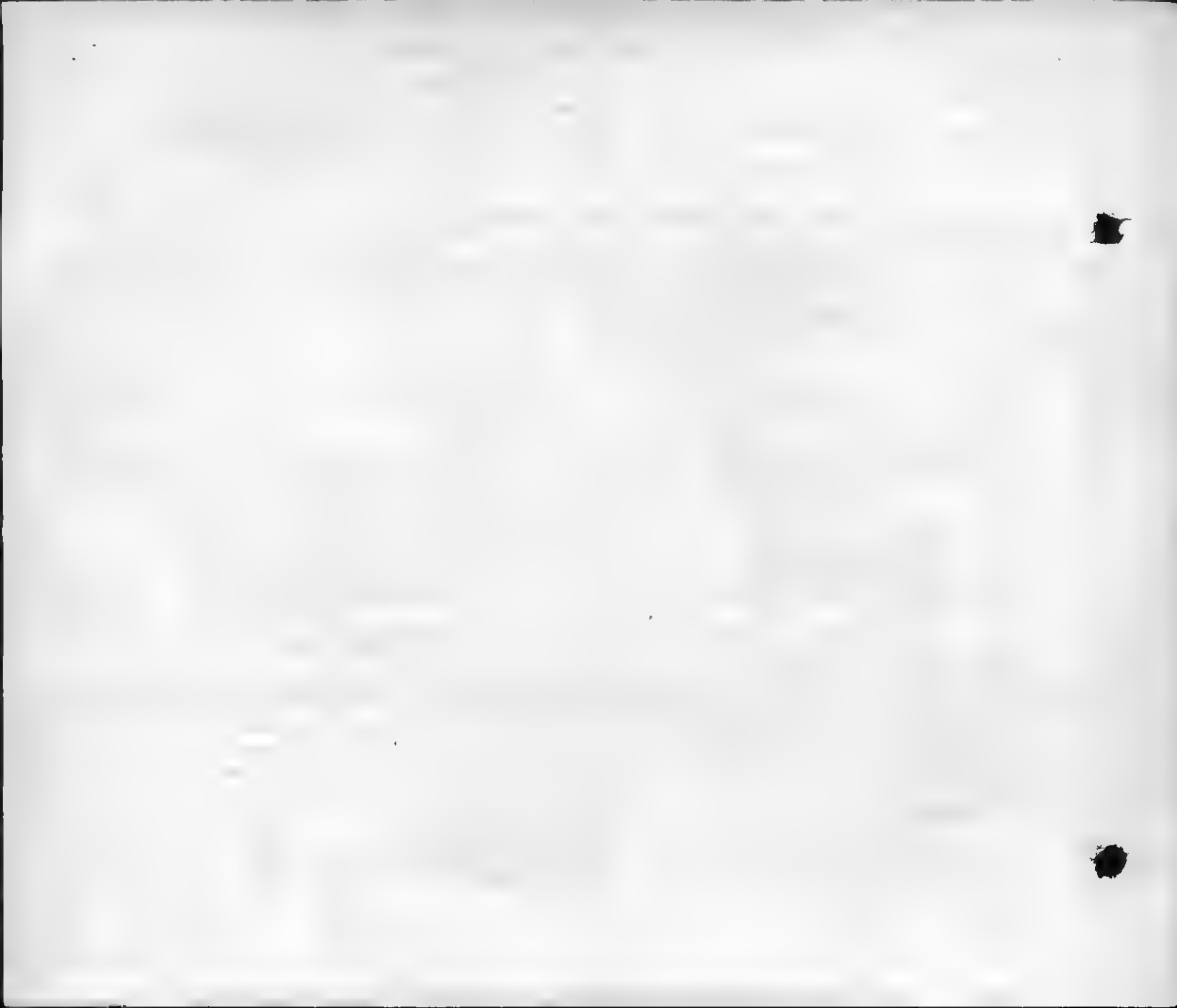
6570

CERTIFICATE OF DEATH

Reg. Dist. No.

06556

| | | | | |
|---|---------------------------|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Balti. Co</u> MARYLAND | | 2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>md</u> b. COUNTY <u>Balti.</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capeville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balti. Md. 53</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Home</u> | | d. STREET ADDRESS <u>6842 Dumbach Rd.</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>Sarah Jane MacDonald</u> | | 4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1958</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/10/79</u> | |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | |
| 11. BIRTHPLACE (State or foreign country) <u>England</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Wm. Fell</u> | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Park</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>Mr. M. Harby</u> | | |
| 17. INFORMANT <u>Mr. M. Harby</u> | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO <u>Age</u> (c) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>Unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>dehydration, diabetes mellitus</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>July</u> 19 <u>56</u> , to <u>June 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>58</u> , and that death occurred at <u>2:40</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4665 EDMONDSON AVE C/14/58</u> DATE SIGNED | | | | |
| ACTUAL SIGNATURE <u>Cliff Ratlife, Jr.</u> M.D. | | DATE SIGNED <u>6/24/58</u> | | |
| PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFE, JR.</u> | | ADDRESS <u>BALTIMORE 29, Md</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | <u>6/26/58</u> | <u>Meadowridge</u> | <u>Howard Co</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. M. Harby</u> | | ADDRESS <u>28</u> | | |
| 24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Albrecht</u> | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6571

CERTIFICATE OF DEATH

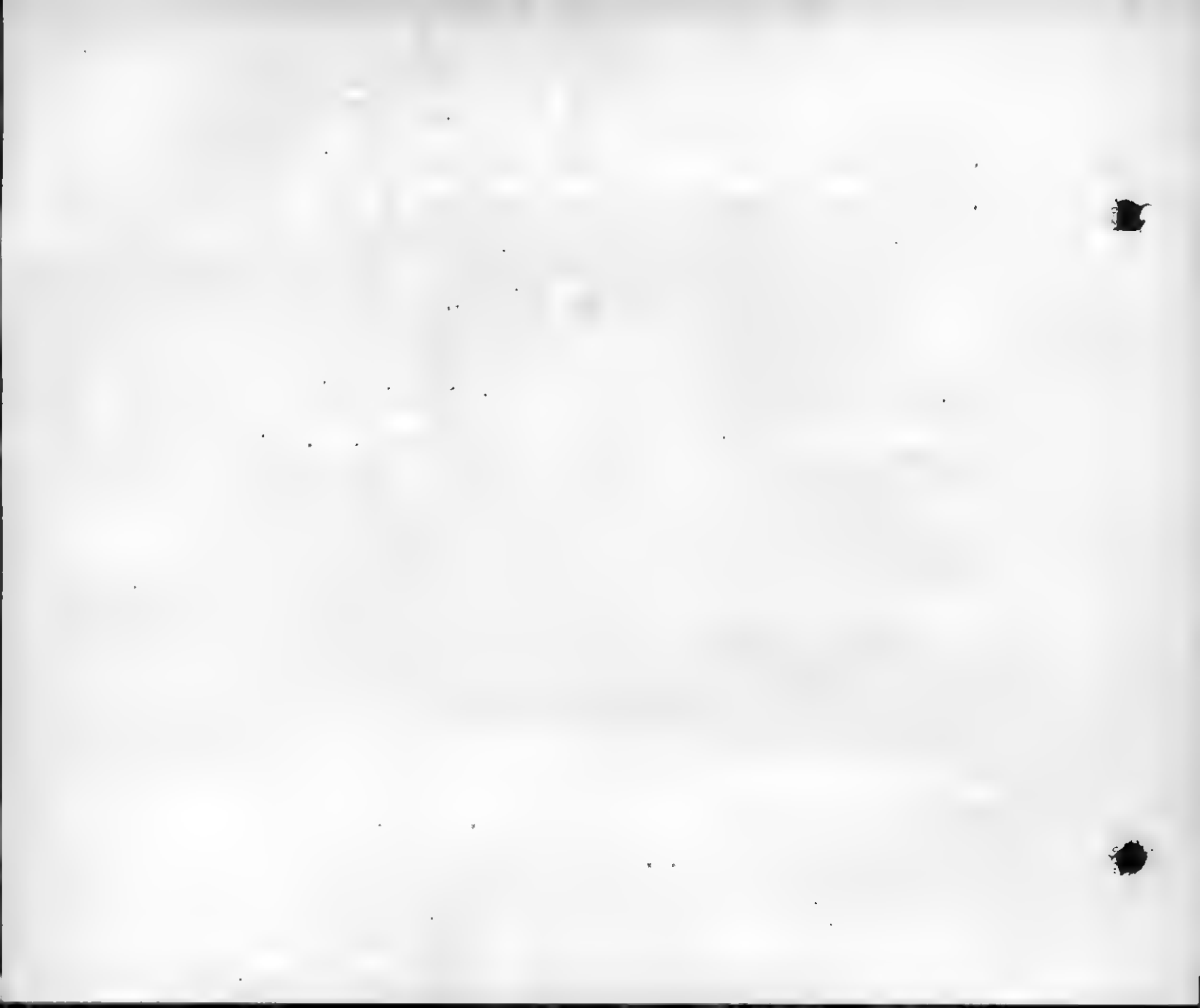
06557

Reg. Dist. No.

32

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore County | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | c. LENGTH OF STAY IN 1b 1 | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND | | b. COUNTY BALTIMORE CITY | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | d. STREET ADDRESS 2314 PRESTON ST. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) FRANK | | First CONRAD | | Middle MARR | | Last MARR | | 4. DATE OF DEATH Month 6 Day 17 Year 1958 | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-19-1901 | | 9. AGE (In years last birthday) 56 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A | | | |
| 13. FATHER'S NAME CONRAD MARR | | | | 14. MOTHER'S MAIDEN NAME ELISABETH HUEGELMEIR HEASELMAYER | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-18-9891 | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERICARDITIS CHRONIC DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) PULMONARY TUBERCULOSIS | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONECTOMY RIGHT. | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-7 , 19 58 , to 6-17 , 19 58 , that I last saw the deceased alive on 6-17 , 19 58 , and that death occurred at 2:00 P. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED | | | | | | | | | |
| ACTUAL SIGNATURE William Newcomer M.D. | | | | PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/21/58 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | | 22d. LOCATION (City, town, or county) (State) Balt. Md | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc. | | | | ADDRESS -2431-35 E. Ohio St. | | 24a. REC'D BY REGISTRAR DATE JUN 23 '58 | | 24b. REGISTRAR'S SIGNATURE W. L. Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



6572

CERTIFICATE OF DEATH

Reg. Dist. No.

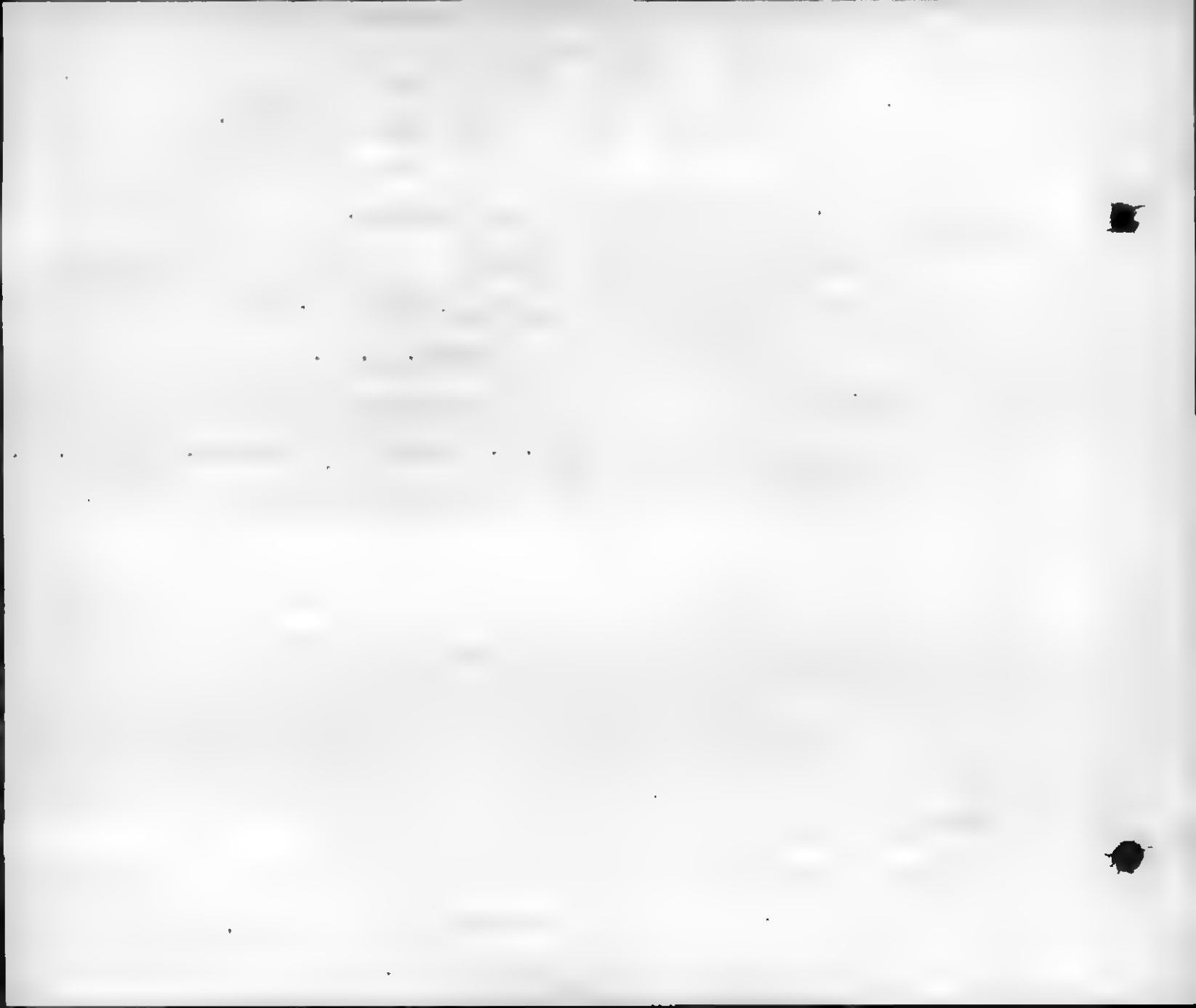
06558

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Balto. | | b. STATE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland | | b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyde Park | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hyde Park | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1530 Galena Rd. | | | | d. STREET ADDRESS 1530 Galena Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Edward | | First Adam | | Middle Marshall | | Last | |
| 4. DATE OF DEATH Month June | | Day 26 | | Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (In years lost birthday) 66 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Frank Marshall | | | | 14. MOTHER'S MAIDEN NAME Veronica Brounsweiger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO 212-10 124 | | 17. INFORMANT Mrs. E. Marshall 1530 Galena Rd. Balto. 21. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Under Sclerotic Heart Disease | | | | | | | |
| DUE TO (b) Essential Hypertension | | | | | | | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 25, 1958 to June 26, 1958 that I lost saw the deceased alive on June 25, 1958 , and that death occurred at 3:45 PM , from the causes and on the date stated above | | | | | | | |
| ACTUAL SIGNATURE Robert J. Snyder M.D. | | | | DATE SIGNED 6/27/58 | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 30, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Sacred Heart | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly | | | | ADDRESS 418 Eastern Pk. | | 24a. REC'D BY REGISTRAR JUN 30 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. H. Beach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

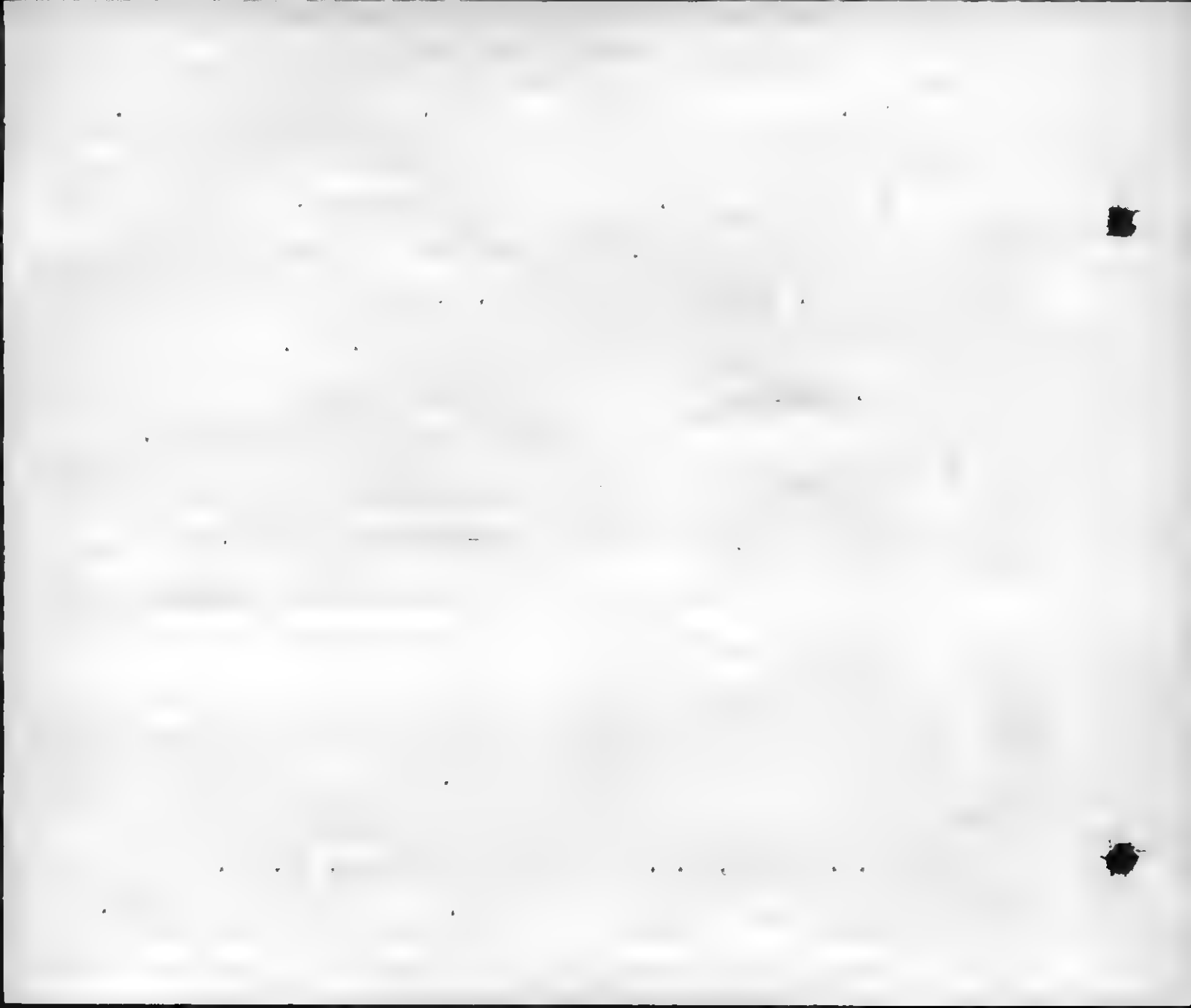
6573

CERTIFICATE OF DEATH

Reg. Dist. No.

06559

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Roberts Ave. | | d. STREET ADDRESS 3 Robert Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last HERMAN F. MATTHEWS | | 4. DATE OF DEATH Month Day Year June 20 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Sept. 11, 1886 |
| 9. AGE (In years last birthday) 71 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Howard Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John W. Matthews | | 14. MOTHER'S MAIDEN NAME Louvenia Thomas | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Naomi Miller | | Address 3 Robert Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency 245X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arterio-sclerotic Heart Disease ? DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | INTERVAL BETWEEN ONSET AND DEATH 98 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from March 15, 1958 , to June 21st, 1958 , that I last saw the deceased alive on June 21st, 1958 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE C.F. Maloney M.D. M.D. 57 Winters Lane 6/21/58 PHYSICIAN'S NAME (Type) C.F. Maloney, M.D. Catonsville, 28. Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 24, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Western Star Cem. | 22d. LOCATION (City, town, or county) (State) Catonsville Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams | | ADDRESS 322 N. Schroeder St. | 24a. REC'D BY REGISTRAR JUN 25 '58 |
| | | 24b. REGISTRAR'S SIGNATURE Qu... | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6574

CERTIFICATE OF DEATH

06560

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Mary Co. - 1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE ST. H.</u> | | d. STREET ADDRESS <u>Mechanicsville</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Virginia Henderson Mattingly</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/10/1907</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>William Mattingly</u> | | 14. MOTHER'S MAIDEN NAME <u>Ada Adams</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Sp. Gr. H. Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Post operative shock</u> DUE TO (c) <u>Hysterectomy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>58</u> , to <u>6/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>58</u> , and that death occurred at <u>10 P.M.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>Spring Grove St. Hospital 6/20/58</u> | |
| PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 24, 58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u> | | 22d. LOCATION (City, town, or county) (State) <u>Maryanna, MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingly</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u> | |
| ADDRESS <u>Frostburg, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Clarke</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

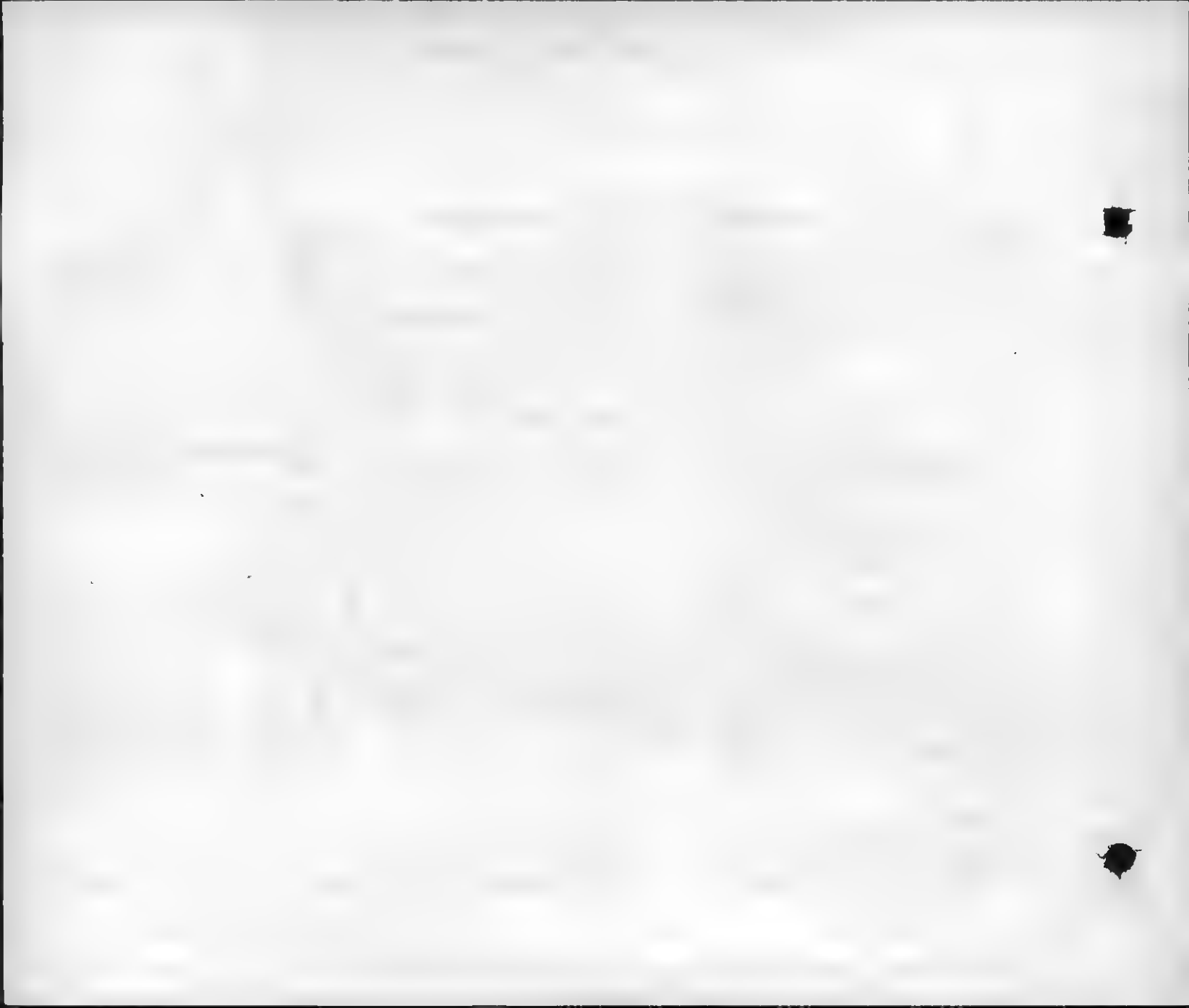
6575

CERTIFICATE OF DEATH

Reg. Dist. No.

06561

| | | | | | | | |
|--|----------------------------------|--|---|--|--|---|---|
| 1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital; give street address) OR INSTITUTION <u>Baltimore County Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>James Henry Maxwell</u> | | | 4. DATE OF DEATH Month Day Year <u>June 22 1958</u> | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 15, 1876</u> | 9. AGE (In years last birthday) <u>81</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stone Molder</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SHEPPARD CO.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>John Maxwell</u> | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Conklin</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u> | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>Balto Co Home Records</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiac-vascular disease; old myocardial infarction; recent gangrene Rt foot</u> DUE TO (b) <u>dissection; old myocardial infarction</u> DUE TO (c) <u>infarction; recent gangrene Rt foot</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>years 3 mos. 1 wk.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 21</u> , 19 <u>58</u> , to <u>June 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Elizabeth B Sherrill</u> M.D. | | | ADDRESS (Street, city or town, state) <u>Cockeysville, Md. 6/22/58</u> | | | | |
| PHYSICIAN'S NAME (Type) <u>Elizabeth B Sherrill</u> | | | DATE SIGNED <u>6/22/58</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6-25-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>5712 O'DONNELL ST., BALTO., MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Geiler</u> | | | | ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u> | | 24a. REC'D BY REGISTRAR <u>June 24 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u> | | | |



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6576

CERTIFICATE OF DEATH

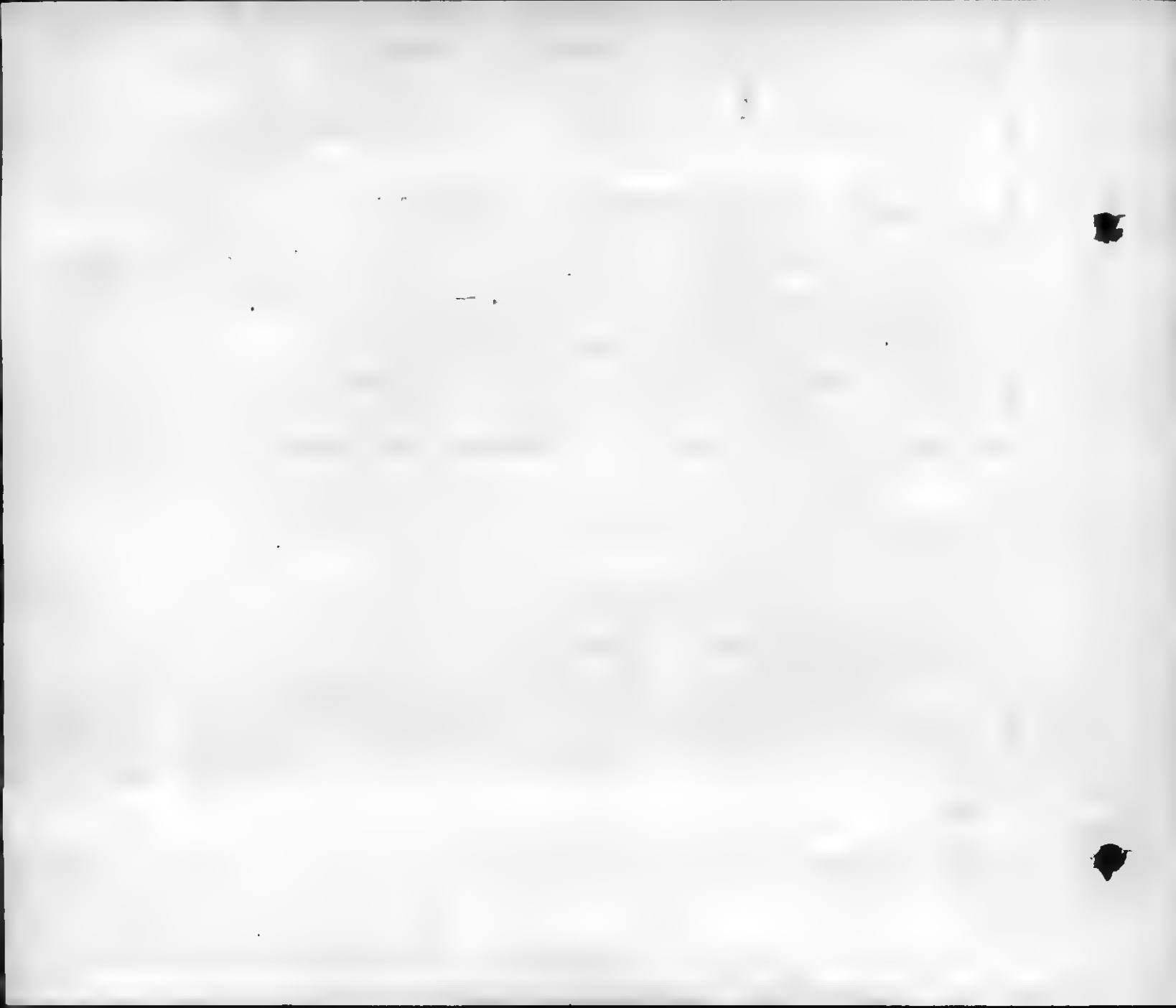
06562

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ruxway Manor Nursing Home | | | | d. STREET ADDRESS 5837 Belair Road | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GLARA MAY | | | | 4. DATE OF DEATH Month Day Year June 11, 1958 19 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 2 1900 | |
| 9. AGE (In years last birthday) 57 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | | 10b. KIND OF BUSINESS OR INDUSTRY Private Homes | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) [If yes, give war or dates of service] No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Baltimore County Welfare Board Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from JAN 1958 , to JUNE 11, 1958 , that I last saw the deceased alive on MAY 1958 , and that death occurred at 4 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE T. C. Sawinski | | | | ADDRESS (Street, city or town, state) 17 W. PENNA AVE. | | DATE SIGNED JUNE 11, 1958 | |
| PHYSICIAN'S NAME (Type) T. C. SIKWINSKI | | | | TOWSON 4MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Removal | | 6-11-58 | | Wald. Med. School | | Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns Bone, Towson, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 13 '58 | | 24b. REGISTRAR'S SIGNATURE Redmond | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6577

CERTIFICATE OF DEATH

06563

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. NAME OF DECEASED (Type or Print) Richard C. May | | 2. DATE OF DEATH June 27, 1958 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION Manor Road, Glen Arm. Md | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Glen Arm. D. STREET ADDRESS (If rural, give location) Box 118 Manor Road, | |
| c. Length of stay in Baltimore Yrs. Mos. Days | 5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Worker | 10B. KIND OF BUSINESS OR INDUSTRY | 8. DATE OF BIRTH Aug. 11, 1878 | 9. AGE (In years last birthday) 79 |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | 12. CITIZEN OF WHAT COUNTRY? USA | 13. FATHER'S NAME James A. May | |
| 14. MOTHER'S MAIDEN NAME Mary Ellen Waite | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mrs. Lloyd L. Boyd, |
| 18. 154X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the rectum DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH 8 mos. | |
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from May 15, 1958 to June 27, 1958 , that I last saw the deceased alive on May 20, 1958 , and that death occurred at 10 a.m. , from the causes and on the date stated above. | | | |
| 23A. SIGNATURE Leonard J. Ruck | 23B. ADDRESS 1001 St. Paul St. | 23C. DATE SIGNED June 27/58 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 6/30/58 | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| DATE RECEIVED BY LOCAL REGISTRAR June 28 1958 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR Leonard J. Ruck 5305 Hartford Road. | |

M L CERTIFICATION

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN, UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be delivered for use as the burial-transit record. The law requires that the funeral director be detached for use as the burial-transit record. Page 3 must be detached for use as the burial-transit record.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6578

CERTIFICATE OF DEATH

Reg. Dist. No.

06564

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN TB ? | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House-in-the-Pines Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Loretta Middle J. Last McCusker | | 4. DATE OF DEATH Month 6 Day 5 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 8, 1873 |
| 9. AGE (In years last birthday) yrs 85 | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY --- | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Thomas McCusker | | 14. MOTHER'S MAIDEN NAME Mary Anne Kerr | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Gerald Kerr- 1017 Francis Ave.-Elkridge, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch. Hypertensive Cardio Vascular Disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/20/- , 19 58 , to 6-5 , 19 58 , that I last saw the deceased alive on 6-5- , 19 58 , and that death occurred at 7:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Wilmer K. Gallagher | | M.D. 6209 Frederick Ave. | |
| PHYSICIAN'S NAME (Type) Wilmer K. Gallagher | | Catonville-28, Md. | |
| 22a. BURIAL, CREMATION, or other disposition Burial | | 22b. DATE THEREOF 6/7/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E. Baltimore Street | | 24a. REC'D BY REGISTRAR DATE JUN 9 '58 | |
| 24b. REGISTRAR'S SIGNATURE Qu... | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6579

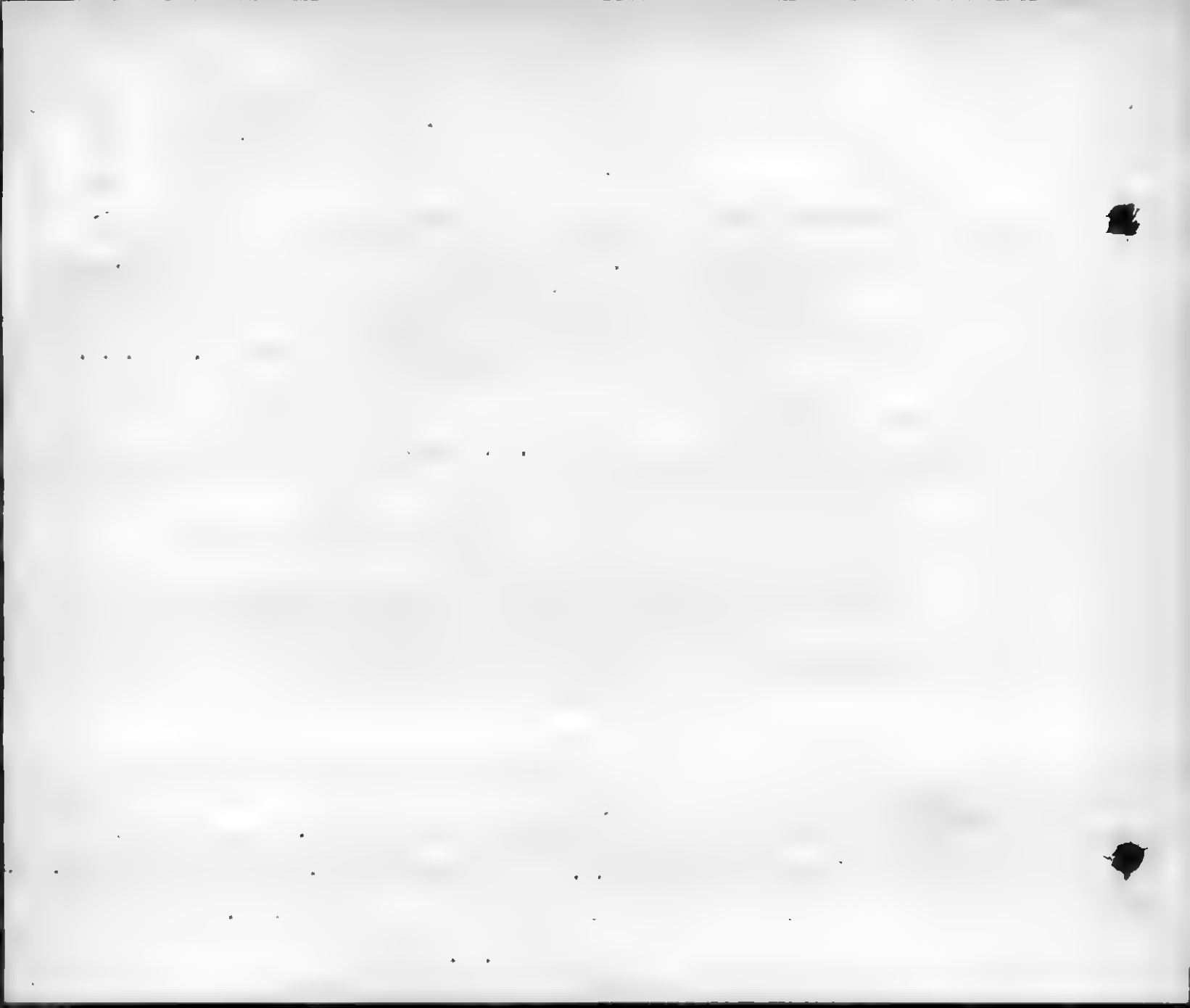
CERTIFICATE OF DEATH

06565

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn | | c. LENGTH OF STAY IN 1b 5 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3645 Campfield Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle A. Last McNAMARA | | 4. DATE OF DEATH Month June Day 4th. Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 22, 1875 |
| 9. AGE (In year, last birthday) yrs. 82 | | IF UNDER 1 YEAR: Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) North Adams, Massachusetts. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John McNamara | | 14. MOTHER'S MAIDEN NAME Mary Kelly | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mrs. M. Kates, 3645 Campfield Road | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per 1a for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA AND DUE TO SUSPECTED CIRRHOSIS WITH LIVER FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (c) 5+ YRS 5+ YRS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year June 7, 1958 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-4-1958 to 6-2-1958 , that I last saw the deceased alive on 6-2-1958 , and that death occurred at 5:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Arts Bldg. DATE SIGNED 6/4/58 | | | |
| ACTUAL SIGNATURE Wm Carl Ebeling M.D. | | PHYSICIAN'S NAME (Type) William Carl Ebeling M.D. | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 7, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lo. Vernon Lamm | | ADDRESS 4611 Park Heights, Balto. Md. | |
| 24a. REC'D BY REGISTRAR DATE JUN 6 '58 | | 24b. REGISTRAR'S SIGNATURE Cliff Leach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6580

CERTIFICATE OF DEATH

Reg. Dist. No.

06566

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|---|-----------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Overlea</i> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5817 Westwood Avenue</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Mr. Joseph C. Meisel, Sr.</i> | | | | 4. DATE OF DEATH <i>June 11th 19 58</i> | | | |
| 5. SEX <i>male</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb. 9, 1889</i> | 9. AGE (In years last birthday) <i>69 yrs.</i> | IF UNDER 1 YEAR | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Electrician</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>John Andrew Meisel</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Kohrs</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i> (If yes, give year or dates of service) <i>W.W. 1</i> | | | | 16. SOCIAL SECURITY NO. <i>218-09-2037</i> | | 17. INFORMANT <i>Mrs. Elizabeth Meisel, 5817 Westwood</i> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA, abdominal, metastatic</i> DUE TO (b) <i>CARCINOMA, prostate</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Dec 1957</i> <i>July 1957</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis, generalized</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <i>Dec. 10, 1957</i> to <i>June 11, 1958</i> that I last saw the deceased alive on <i>June 4, 1958</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Charles V. Sevcik</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>5100 Highland Rd. Baltimore 6 Md.</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Charles V. SEVCIK</i> | | | | DATE SIGNED <i>6/11/58</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6/11/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE <i>Overlea</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06567

6581

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Calvert PRINCES GEORGES | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 7mths19dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. STREET ADDRESS 2306 Rittenhouse St. | |
| 3. NAME OF DECEASED (Type or print) First Lenora Middle Elma Last Merrill | | 4. DATE OF DEATH Month June Day 10 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 15, 1883 |
| 9. AGE (In years last birthday) yrs. 74 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife + CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Jeremiah Elms | | 14. MOTHER'S MAIDEN NAME Elizabeth Gartrell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure due to arteriosclerotic cardio-vascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) vascular disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the rectum | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct. 17 , 19 57 , to June 10 , 19 58 , that I last saw the deceased alive on June 10 , 19 58 , and that death occurred at 11:25 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE Stella Wachslor M.D. | | SPRING GROVE STATE HOSPITAL | |
| PHYSICIAN'S NAME (Type) Stella Wachslor, M.D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-13-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | 22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Washington, D.C. | | 24a. REC'D BY REGISTRAR JUN 13 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. W. Chambers | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6582

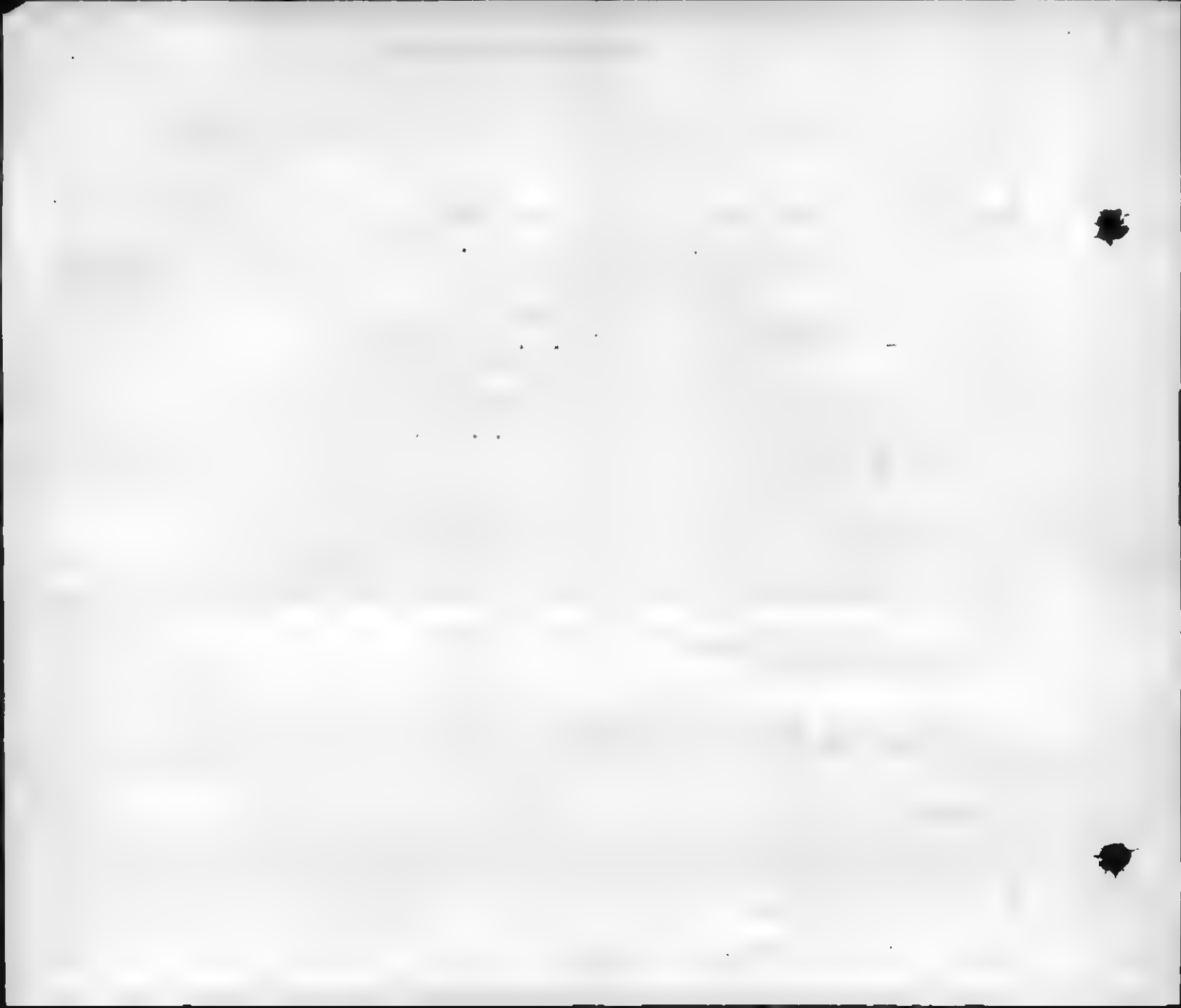
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Long Green Pike | | e. STREET ADDRESS Long Green Pike | |
| 3 NAME OF DECEASED (Type or print) First ELLWOOD A. Middle METZ , Sr. Last | | 4. DATE OF DEATH Month June 13, Day Year 1958 | |
| 5 SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 22, 1884 |
| 9. AGE (In years next birthday) yrs. 74 | | IF UNDER 1 YEAR: Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President-retired | | 10b. KIND OF BUSINESS OR INDUSTRY Box Machine Mfg. Co. | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Allen Metz | | 14. MOTHER'S MAIDEN NAME Emma Leighton | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None | | 17. INFORMANT Address Mrs. E.A. Metz, Glen Arm, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident 4 x 100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from October 1955 , to June 13, 1958 , that I last saw the deceased alive on June 11, 1958 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1014 St Paul St, Balt 2, Md. DATE SIGNED | | | |
| ACTUAL SIGNATURE J. Frank Supplee, III | | M.D. 1014 St Paul St, Balt 2, Md. | |
| PHYSICIAN'S NAME (Type) J. Frank Supplee, III | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 17, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Trinity Episcopal Cemetery | 22d. LOCATION (City, town or county) (State) Long Green, Maryland |
| 23 FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland | | 24a. REC'D BY REGISTRAR DATE JUN 18 '58 | 24b. REGISTRAR'S SIGNATURE Allegre |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6583

CERTIFICATE OF DEATH

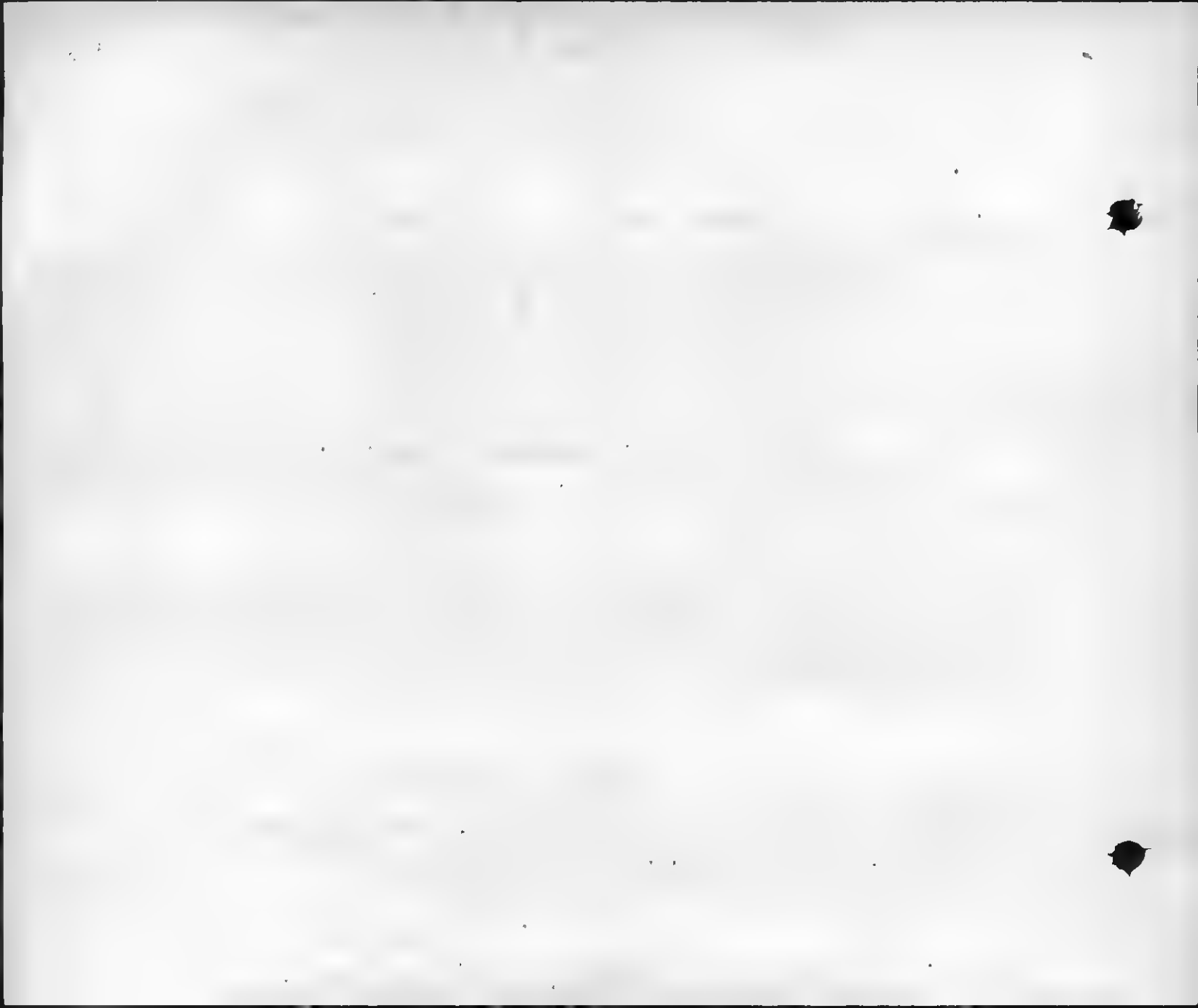
Reg. Dist. No.

6569

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore County | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland | | c. LENGTH OF STAY IN 1b 1 | | 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOOLFORD | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital | | | | d. STREET ADDRESS NONE | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) GEORGE | | First SEORSE | | Middle RANDOLPH | | Last MILLS | | 4. DATE OF DEATH Month 6 Day 1 Year 1958 | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 2-20-1893 | | 9. AGE (In years last birthday) 65 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD | | 11. BIRTHPLACE (State or foreign country) MADISON, MD. | | 12. CITIZEN OF WHAT COUNTRY USA | | | |
| 13. FATHER'S NAME JOHN R. MILLS | | | | 14. MOTHER'S MAIDEN NAME SARAH HALL | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 2-27 , 19 58 , to 6-1 , 19 58 , that I last saw the deceased alive on 6-1 , 19 58 , and that death occurred at 11:58 AM, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland PHYSICIAN'S NAME (Type) William Newcomer, M.D. Superintendent | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-4-58 | | 22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park | | 22d. LOCATION (City, town, or county) (State) Cambridge, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE The H.H. Hubbard Funeral Home, 4701 Wilkens Ave | | | | ADDRESS Balto., Md. | | 24a. REC'D BY REGISTRAR RM 4 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. Hubbard | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 s. should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

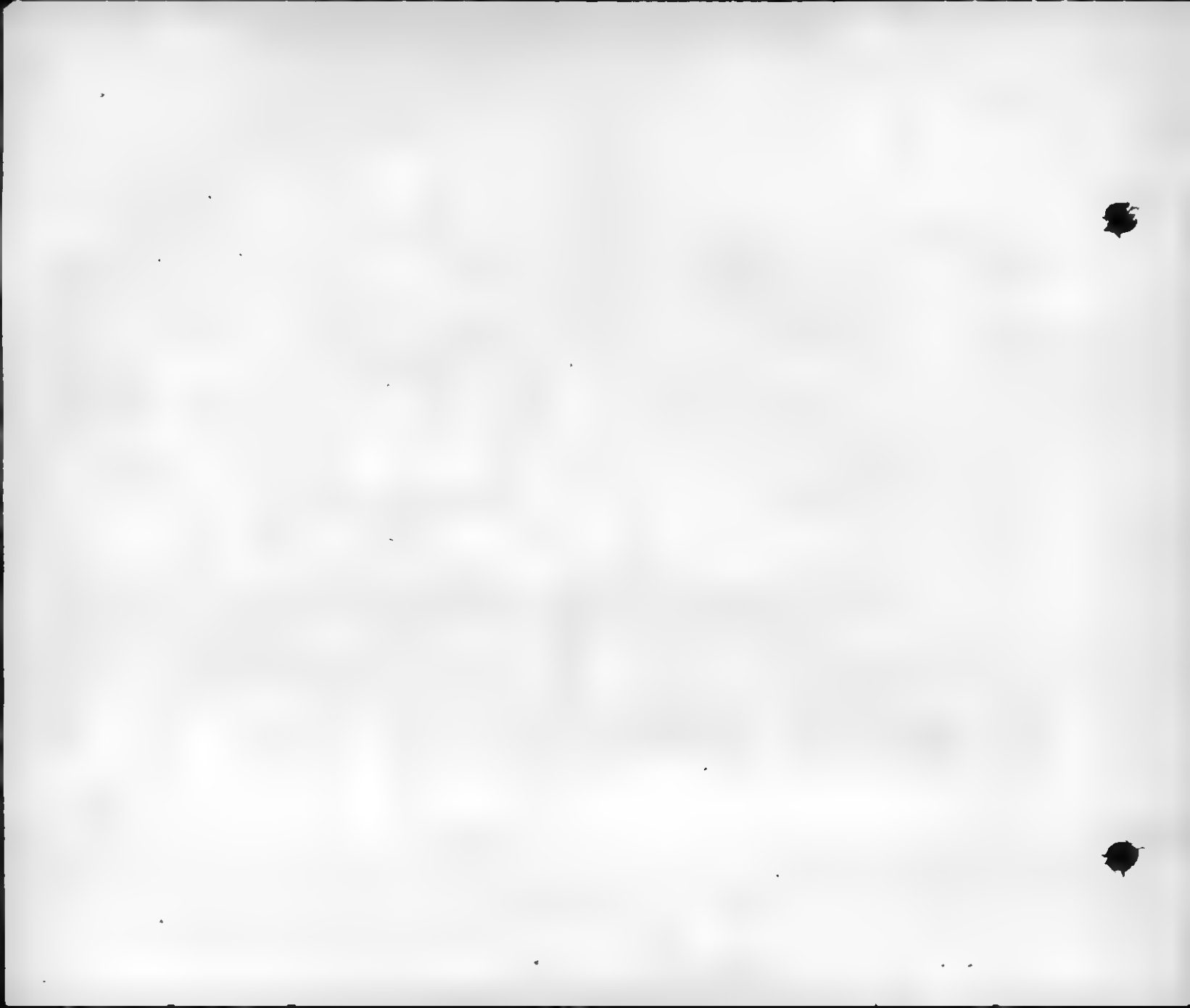
06570

Reg. Dist. No.

| | | | | | |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission). a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges Mills</u> | | c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Princeton State Training School</u> | | | d. STREET ADDRESS <u>844 Howard St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>RICHARD JOS. MOLESWORTH</u> | | | 4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1958</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-28-24</u> | | 9. AGE (In years last birthday) <u>34</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (State or foreign country) <u>Berlin, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>Jos. E. Molesworth</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mrs. F. Irene Day</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Princeton Hosp. - Prince Georges Mills</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>status epilepticus</u> DUE TO <u>cerebral arterio-sclerotic changes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal pneumonia</u> DUE TO <u>terminal pneumonia</u> (c) <u>microcephaly</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>since birth</u> <u>since birth</u> <u>since birth</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>None</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> <u>pm</u> <u>June 8 1958</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Princeton Hosp. - Prince Georges Mills</u> | | 20f. (City or town) (County) (State) <u>Berlin, Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE <u>L. L. Caples</u> | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | |
| EXAMINER'S NAME (Type) <u>D. D. CAPLES</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 10/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Memorial Gardens, Finksburg, Md.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Finksburg, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u> | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 10 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

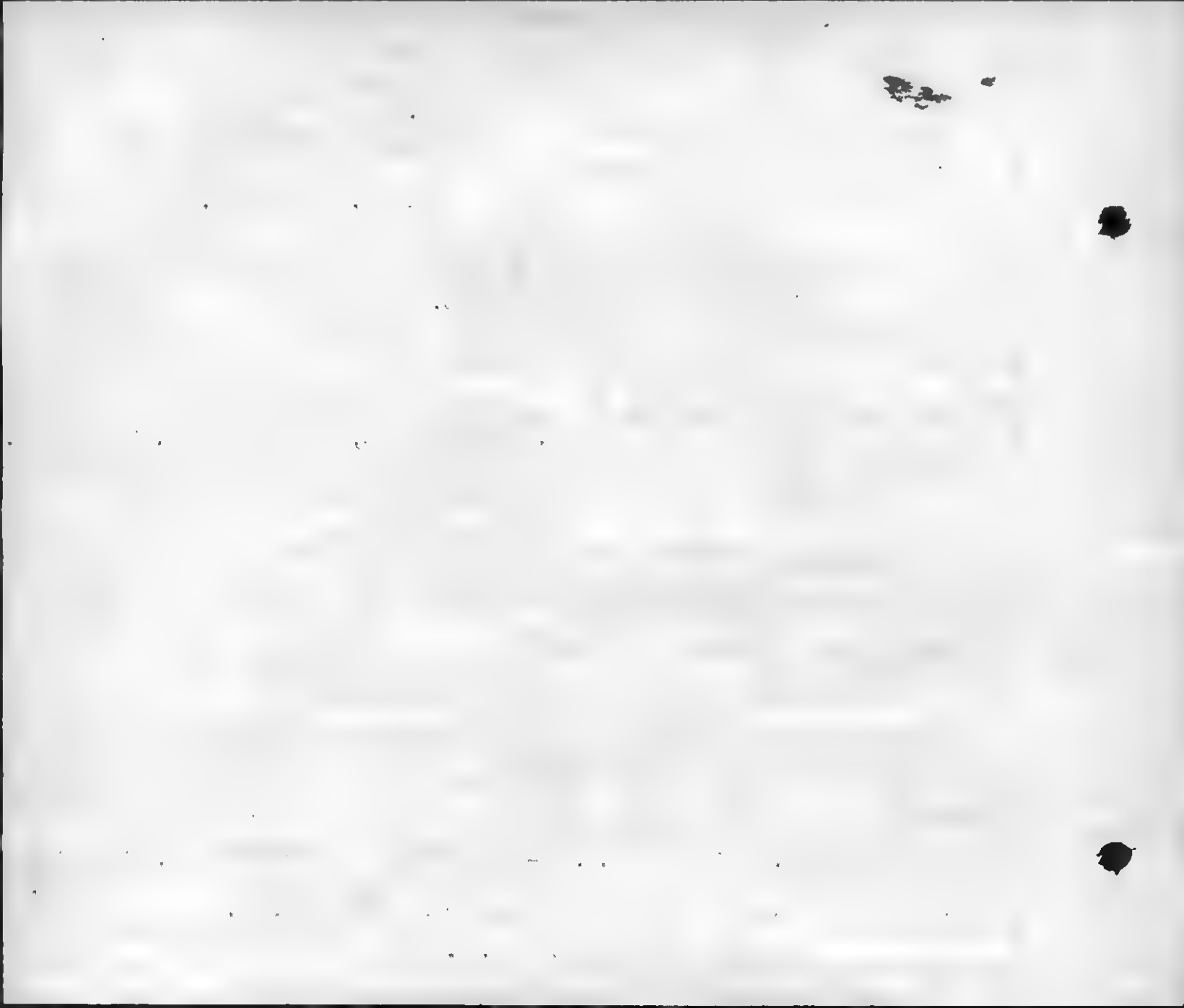
6585

CERTIFICATE OF DEATH

06571

Reg. Dist. No.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOLL GATE, (OWINGS MILLS) c. LENGTH OF STAY IN 1b 6 weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION # 7 Millgate Road | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 3417 St. Ambrose Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First AGATHA Middle MONTALTO Last MONTALTO | | 4. DATE OF DEATH Month June Day 12 Year 1958 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 1st, 1875 |
| 9. AGE (In years last birthday) 83 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? Italy | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mr. Nicholas Abate, 4203 Colonial Rd. Pikesville Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis - generalized DUE TO Arteriosclerotic CV Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Possible Carcinoma (b) Possible Carcinoma (c) Possible Carcinoma INTERVAL BETWEEN ONSET AND DEATH Years Years Year | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 31, 1958 to June 12, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 8:00 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Clarence E. McWilliams M.D. | | ADDRESS (Street, city or town, state) Reisterstown, Maryland DATE SIGNED June 12, 1958 | |
| PHYSICIAN'S NAME (Type) Clarence E. McWilliams, M.D. -- Reisterstown & Cherry Hill Rds. Reisterstown, | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 16, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery, | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE William L. Lannon ADDRESS 4611 Park Heights, Balto. Md. | | 24a. REC'D BY REGISTRAR JUN 16 '58 | 24b. REGISTRAR'S SIGNATURE John J. Lannon |



6471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENDALK</u> c. LENGTH OF STAY IN 1b <u>LIFE</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENDALK (22)</u> | |
| 3. NAME OF DECEASED (Type or print) <u>RICHARD HENRY MONTANARI</u> 4. DATE OF DEATH <u>6/14/58</u> 5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 8. DATE OF BIRTH <u>AUG. 17, 1940</u> 9. AGE (in years last birthday) <u>17</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13. FATHER'S NAME <u>JOHN J. MONTANARI</u> 14. MOTHER'S MAIDEN NAME <u>HELEN DE SARRO MONTANARI</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>JOHN J. MONTANARI</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fatigued</u> DUE TO (c) <u>10 min.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subject drowned while swimming</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Patuxent River</u> 20f. (City or town) (County) (State) <u>BALTO.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Jack Collins</u> EXAMINER'S NAME (Type) <u>JACK COLLINS, MD</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/16/58</u> | |
| 22a. BURIAL CREMATION, (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>6/17/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART JESUS</u> 22d. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD</u> | | 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brock Bradley, Dendalk, MD</u> 24. REC'D BY REGISTRAR <u>18 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Overbeach</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



6555

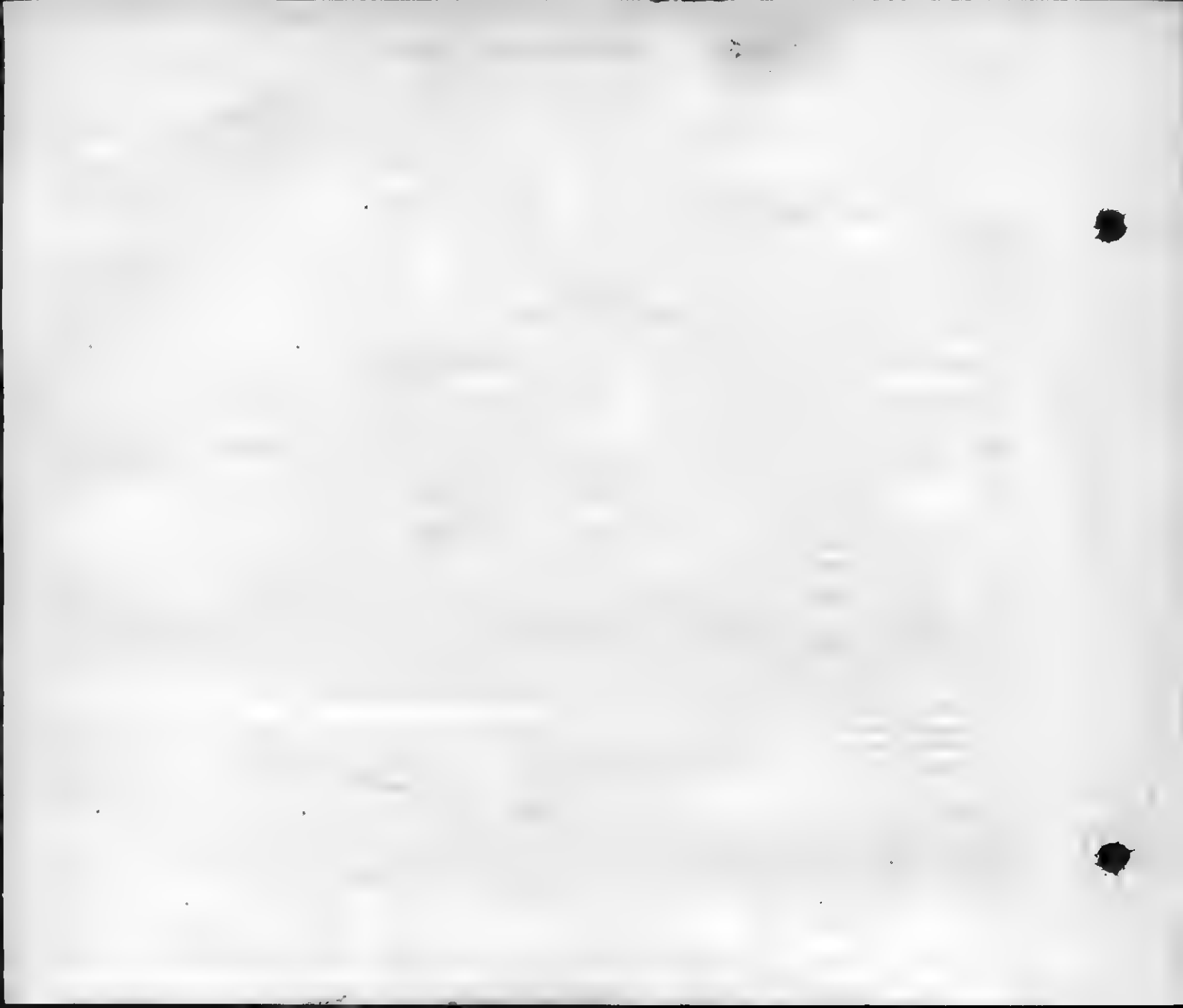
CERTIFICATE OF DEATH

06573

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton (rural)</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u> | | | | e. STREET ADDRESS <u>Manor Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Morrison</u> Last <u>Morrison</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-24-81</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. | IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u> | IF UNDER 24 HRS. Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>unknown Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Mike Morrison</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah ?????</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Records Spring Grove State Hospital</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiovascular disease</u> <u>482.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO (c) <u>?</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>? 5 months</u> <u>?</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration, malnutrition, decubitus ulcers,</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 22</u> , 19 <u>58</u> , to <u>June 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>58</u> , and that death occurred at <u>2:15A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Spring Grove Hosp. Baltimore 28, Md.</u> DATE SIGNED <u>6/13/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>C. Eugene Watermann</u> | | | | PHYSICIAN'S NAME (Type) <u>C. Eugene Watermann</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-16-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Clynmalira Methodist</u> | | 22d. LOCATION (City, town, or county) (State) <u>Monkton, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Brooks</u> | | | | 24a. REC'D BY REGISTRAR <u>622 York Rd Towson</u> | | 24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06574

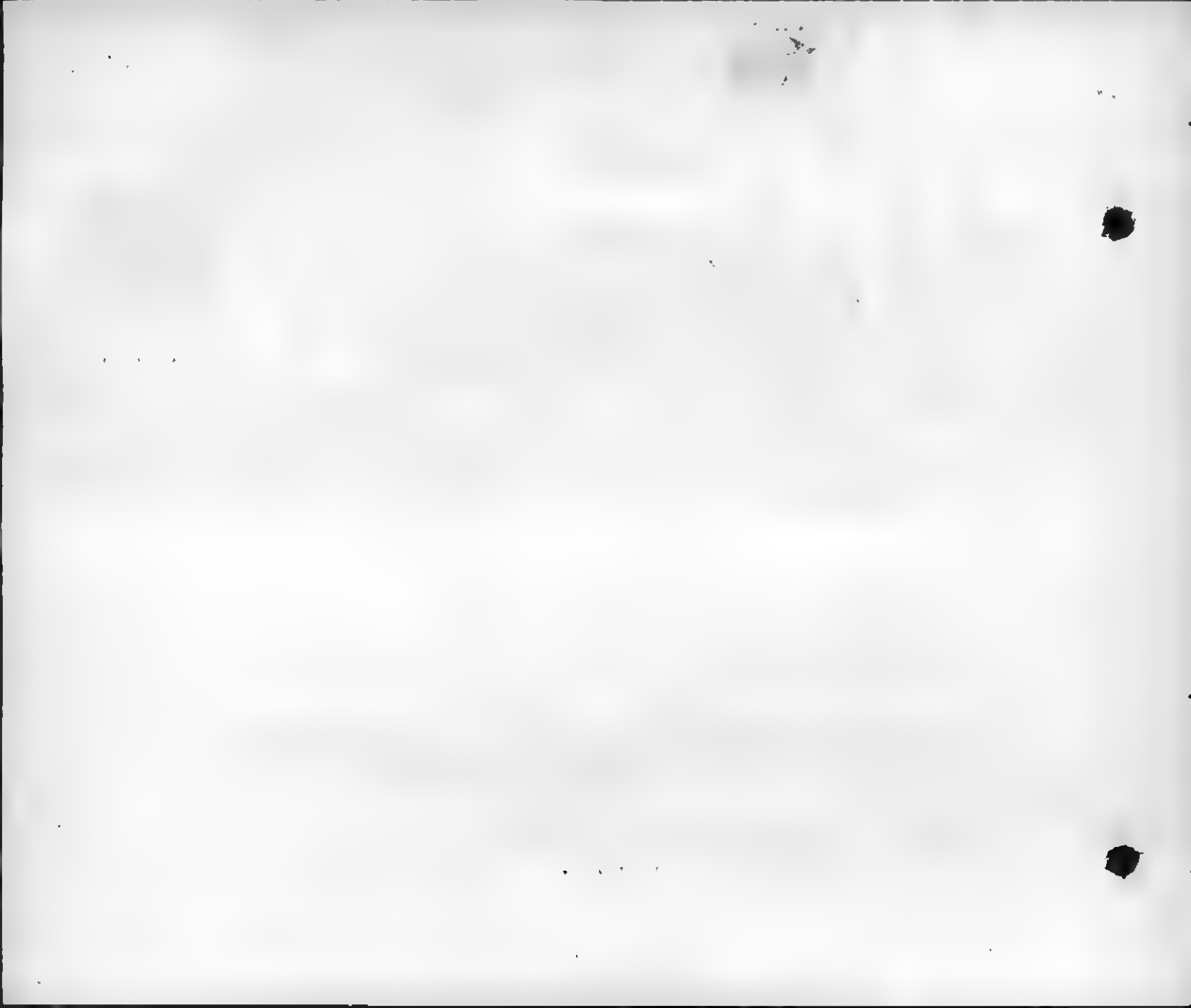
6587
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1mth 5dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| | | f. STREET ADDRESS 2601 Madison Avenue | |
| 3. NAME OF DECEASED (Type or print) First Isador Middle Mount Last Mount | | 4. DATE OF DEATH Month June Day 26 Year 19 58 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 17, 1887 |
| 9. AGE (In years last birthday) yrs 71 | | 10. IF UNDER 1 YEAR: IF UNDER 74 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired jobber | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Europe | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis | | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) Arteriosclerotic cardiovascular disease | | | |
| DUE TO (c) Arteriosclerosis, generalized and severe | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from May 28 , 19 58 , to June 26 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at 4:30 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gertrude Fleischmann M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-26-58 | |
| PHYSICIAN'S NAME (Type) Gertrude Fleischmann, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | 6-27-1958 | Balto Hebrew | Balto Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis | | ADDRESS 2100 Eutaw St | 24a. REC'D BY REGISTRAR DATE JUN 27 '58 |
| | | 24b. REGISTRAR'S SIGNATURE Rebecca | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06575

6588

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 2yr11mth3dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. STREET ADDRESS R. F. D. #1 | |
| 3. NAME OF DECEASED (Type or print) First Magdalene Middle Nalley Last Nalley | | 4. DATE OF DEATH Month June Day 30 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 23, 1882 |
| 9. AGE (In years last birthday) 76 yrs | | IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min 76 | IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min 76 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Joseph L. Nalley | | 14. MOTHER'S MAIDEN NAME Kathryn L. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma of the lungs | | | |
| 170X DUE TO | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the breast (removed in 1953) | | | |
| DUE TO (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 19 19 58 , to June 30 19 58 , that I last saw the deceased alive on JUNE 30 19 58 , and that death occurred at 6:30a. M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE Bruno Radawski M.D. | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-30-58 | |
| PHYSICIAN'S NAME (Type) BRUNO RADALUSKAS | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 3, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Washington D. C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons | | ADDRESS Hyattsville Maryland. | |
| 24a. REC'D BY REGISTRAR JUL 2 '58 | | 24b. REGISTRAR'S SIGNATURE W. J. Radawski | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 1. 1.

2.

3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

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06576

6585 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Balto. Co.</u> | MARYLAND | STATE <u>MD.</u> | COUNTY <u>Balto.</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) | LENGTH OF STAY (in this place) | CITY OR TOWN <u>Steuers</u> | (If rural give location) |
| TOWN <u>Steuers (RD)</u> | | STREET ADDRESS | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| <u>William E Newhauser</u> | | <u>June 1, 1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <u>Feb 1-1896</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| <u>Carpenter</u> | | | <u>Balto Co</u> |
| 13. FATHER'S NAME <u>JOHN N. NEWHAUSER</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Russell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| (If Yes, give year or dates of service) | | 17. INFORMANT & ADDRESS <u>SAM NEWHAUSER Glen Ar Md</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure 2 days</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>With Pulmonary Edema</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart Dis.</u> | | <u>6 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office, bldg., etc.) | |
| | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| | | 21f. HOW DID INJURY OCCUR? | |
| | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb. 8, 1953</u> to <u>5/17, 1958</u> , that I last saw the deceased alive on <u>5/17, 1958</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above | | | |
| SIGNATURE <u>Clifford F. Hudson</u> | | DATE SIGNED <u>5/15/58</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23. NAME OF CEMETERY OR CREMATORY | |
| DATE THEREOF <u>June 4-1958</u> | | LOCATION (City, town, or county) (State) | |
| 24. REC'D BY REGISTRAR | | 25. FUNERAL DIRECTOR'S SIGNATURE | |
| REGISTRAR'S SIGNATURE <u>Clifford F. Hudson</u> | | ADDRESS <u>1-01 R K. MD</u> | |
| DATE <u>JUN 9 '58</u> | | ADDRESS <u>8869 Hartford</u> | |

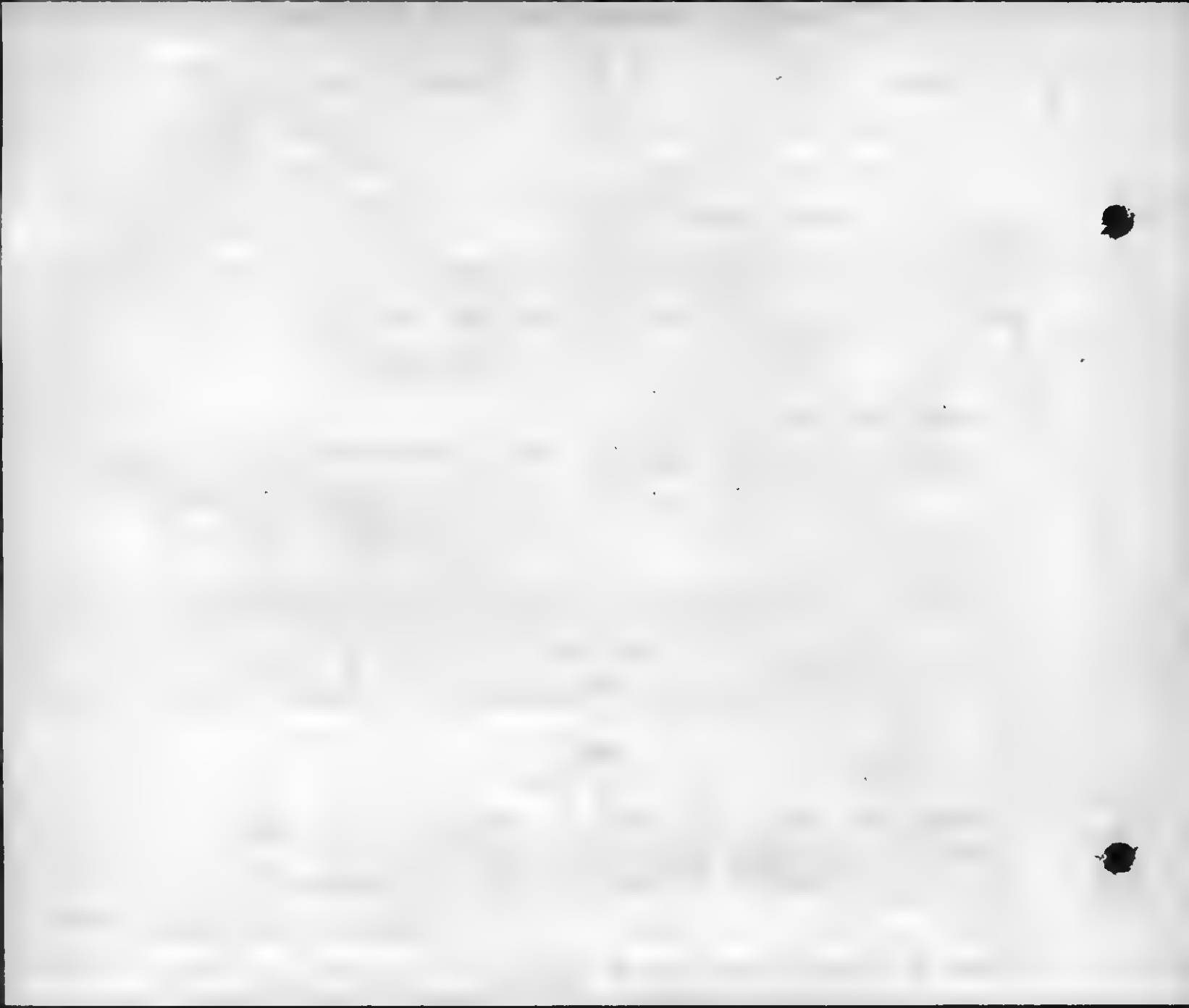
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 and 4 be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

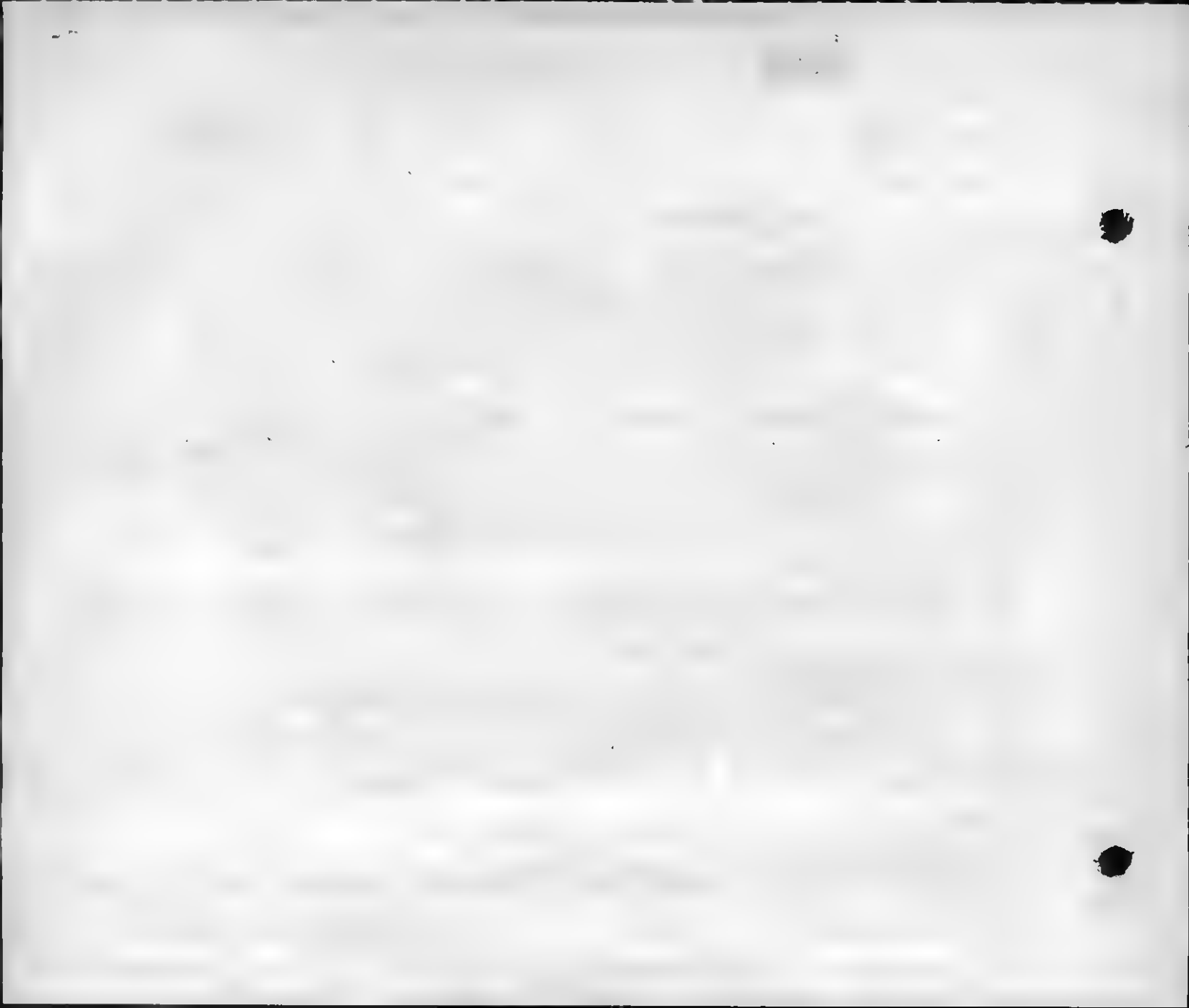
6590

CERTIFICATE OF DEATH

Reg. Dist. No.

06578

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3013 Delmar Ave</u> | | | | d. STREET ADDRESS <u>3013 Delmar Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>EDWIN</u> Middle <u>C.</u> Last <u>NICHOLS</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/20/1900</u> | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS Hours <u> </u> Min <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roller</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u> | | 11. BIRTHPLACE (State or foreign country) <u>Barn at Sea</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Gustav Nichols</u> | | | | 14. MOTHER'S MAIDEN NAME <u> </u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u> | | | | 16. SOCIAL SECURITY NO <u> </u> | | | |
| 17. INFORMANT <u>Ray E. Nichols</u> | | | | Address <u>3013 Delmar Ave</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE AND ARTERIOSCLEROTIC</u> <u>12X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIO-VASCULAR RENAL DISEASE</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u> </u> <u> </u> <u>19</u> | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1951</u> , 19 <u> </u> , to <u>6-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-2</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Herman J. Halperin</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED <u>SPARROWS PT., 19 MD 6-5-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>HERMAN J. HALPERIN</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/7/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home, Dundalk, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07707

6591

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Pulaski | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hiwassee ✓ | |
| c. LENGTH OF STAY IN 1b 3 Days | | d. STREET ADDRESS Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Old Court Rd. | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James A. Middle Garfield Last Nunn | | 4. DATE OF DEATH Month June Day 25 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-12-1895 |
| 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY for Self | |
| 11. BIRTHPLACE (State or foreign country) Pulaski, Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jasper Nunn | | 14. MOTHER'S MAIDEN NAME Naomi Spence | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes (If yes, give year or dates of service) W.W.#1 | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Nancy Nellie Nunn, Pulaski Virginia | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 2-3 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 23rd 1958 to June 25, 1958 , that I last saw the deceased alive on June 24th 1958 , and that death occurred at 1:30 A.M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE James A. Miller M.D. | | DATE SIGNED 6/27/58 | |
| PHYSICIAN'S NAME (Type) James A. Miller M.D. | | ADDRESS (Street, city or town, state) 1331 Reisterstown Rd. Pikesville - Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-27-58 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Havel, Pikesville, Md. | | 24a. REC'D BY REGISTRAR DATE JUL 15 58 | 24b. REGISTRAR'S SIGNATURE W. H. Smith |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Item 9, Film G231, 7/11/58

CERTIFICATE OF DEATH

06579

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1 mth3dys | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | / d. STREET ADDRESS 617 Woodsdale Road | |
| 3. NAME OF DECEASED (Type or print) First John Middle Oberseider Last Oberseider | | 4. DATE OF DEATH Month June Day 30 Year 19 58 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 25, 1876 |
| 9. AGE (In years last birthday) 82 1/2 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME John Oberseider | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 23 , 19 58 , to June 30 , 19 58 , that I last saw the deceased alive on June 30 , 19 58 , and that death occurred at 9:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 7-1-58 | | | |
| ACTUAL SIGNATURE Augusto Jose Esquibel, M. D. | | M. D. SPRING GROVE STATE HOSPITAL | |
| PHYSICIAN'S NAME (Type) Augusto Jose Esquibel, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/3/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Ann's Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John + Son | | ADDRESS 28 | |
| 24a. REC'D BY REGISTRAR DATE 7 58 | | 24b. REGISTRAR'S SIGNATURE W. J. ... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

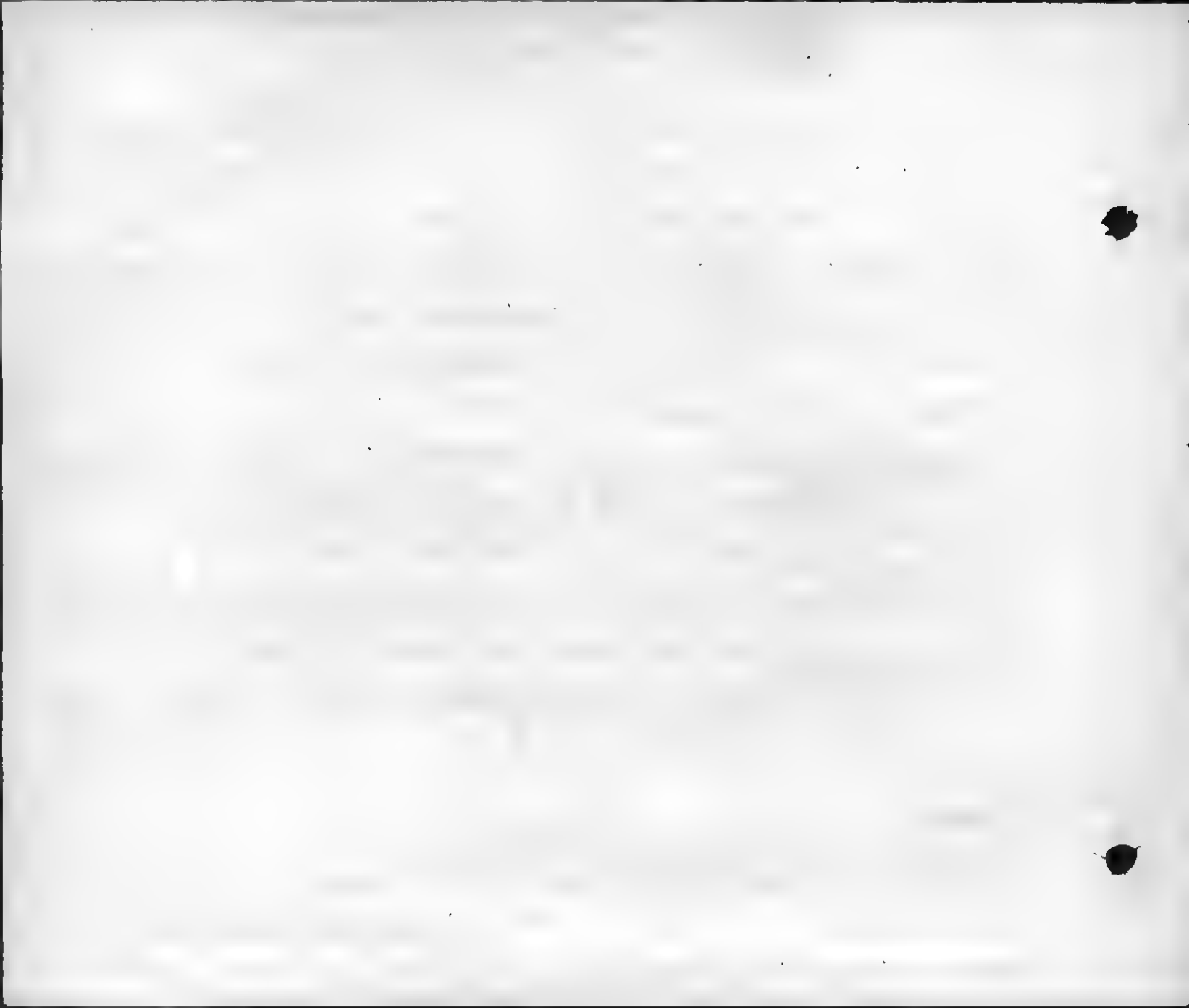
6593

CERTIFICATE OF DEATH

06581

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9740 Magledt Road</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Mrs. Mary Agnes</i> Middle <i>O'Donnell</i> Last <i>O'Donnell</i> | | | | 4. DATE OF DEATH Month <i>June</i> Day <i>2nd</i> Year <i>1958</i> | | | |
| 5. SEX <i>female</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Feb. 5, 1867</i> | |
| 9. AGE (In years last birthday) <i>91</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Michael Cooney</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Bridget Hughes</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i> | | 17. INFORMANT Address <i>Miss Blanche L. O'Donnell, same</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary-vascular hemorrhage</i> DUE TO <i>Atherosclerotic hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>vascular disease</i> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>25+ yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <i>May 31, 1958</i> to <i>June 2, 1958</i> , that I last saw the deceased alive on <i>May 31, 1958</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Frank T. Kasik Jr.</i> M.D. | | | | ADDRESS (Street, city or town, state) <i>9005 Harford Rd Baltimore 14 Md.</i> | | | |
| DATE SIGNED <i>6/2/58</i> | | | | | | | |
| PHYSICIAN'S NAME (Type) <i>FRANK T KASIK JR.</i> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>6/5/58</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i> | | | | 24a. REC'D BY REGISTRAR <i>JUN 3</i> DATE | | 24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

CERTIFICATE OF DEATH

06582

Reg. Dist. No.

6594

| | | | | | | | |
|---|--|---------------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 4</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8522 Stater Oak Rd.</u> | | | | d. STREET ADDRESS <u>18522 Stater Oak Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Edwin L. Otto Sr.</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 8 1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 25, 1880</u> | |
| 9. AGE (In years last birthday) yrs <u>77</u> | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Albert Otto</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Bertha Finzelburg</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Edwin L. Otto Jr. - 8522 Stater Oak Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lungs</u> | | | | | | | |
| 1657 DUE TO | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO | | | | | | | |
| (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that I attended the deceased from <u>6/5 1958</u> to <u>6/8 1958</u> , that I last saw the deceased alive on <u>6/8 1958</u> , and that death occurred at <u>6:30 A.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Gordon Grau</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>2523 Loch Raven Blvd</u> DATE SIGNED <u>6/9/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Gordon Grau, M. D.</u> | | | | TOWN OF <u>MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>6/11/58</u> | | <u>Baltimore Cemetery</u> | | <u>Balto. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John C. Miller Inc. - 2431-35 E. Olive St.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 12 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. S. Search</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: File to requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6595

CERTIFICATE OF DEATH

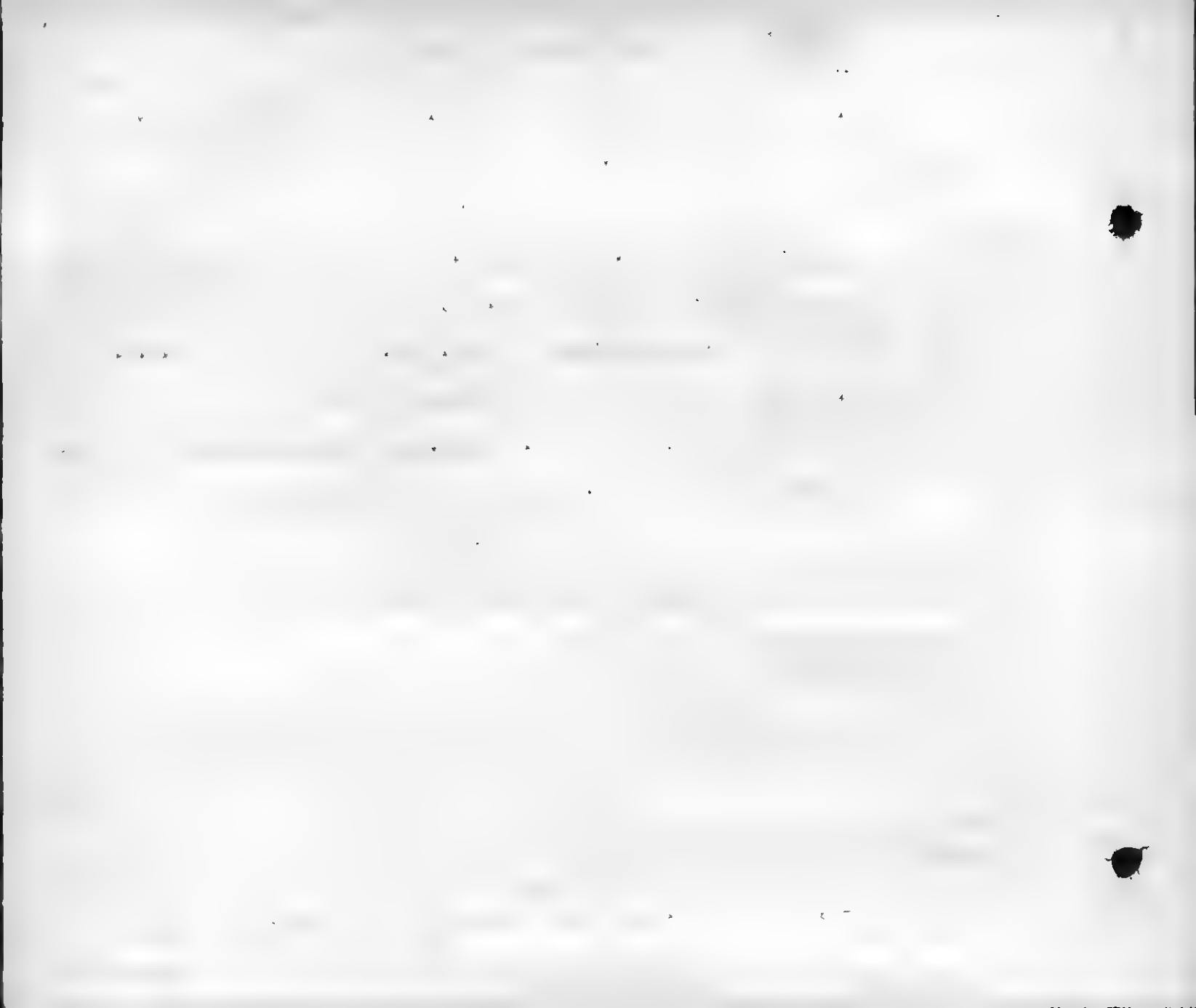
Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock | | | |
| c. LENGTH OF STAY IN 1b 11 Yrs. | | | | d. STREET ADDRESS 11 Hernwood Road | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hernwood Road | | | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle J. Last Peach Sr. | | | | 4. DATE OF DEATH Month June Day 3rd Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> REINVESTED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH Aug. 15, 1878 | |
| 9. AGE (In years last birthday) yrs. 79 | | IF UNDER 1 YEAR: Months 3rd Days 18 Hrs. 58 | | IF UNDER 24 HRS. Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Cutter | | | | 10b. KIND OF BUSINESS OR INDUSTRY Granite Business | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Charles J. Peach | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Kelly | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | (If yes, give year or date of service) ***** | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Nora M. Peach Address Hernwood Road, Woodstock. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung - it - c 160X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized carcinomatosis DUE TO (c) Chronic bronchitis & Silicosis INTERVAL BETWEEN ONSET AND DEATH 5 years 20 years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from APRIL , 1958, to JUNE 3 , 1958, that I last saw the deceased alive on JUNE 3 , 1958, and that death occurred at 3:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thomas E. Wheeler M.D. | | | | ADDRESS (Street, city or town, state) 3601 CLIFMAR RD | | DATE SIGNED 6/4/58 | |
| PHYSICIAN'S NAME (Type) THOMAS E. WHEELER | | | | Balto 5 - Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-6, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY St. Alphonsus Cemetery | | 22d. LOCATION (City, town, or county) (State) Woodstock, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers | | | | ADDRESS 8728 Liberty Road | | 24a. REC'D BY REGISTRAR DATE JUN 10 '58 | |
| LORING BYERS | | | | Randallstown, Md | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6596

CERTIFICATE OF DEATH

Reg. Dist. No.

06584

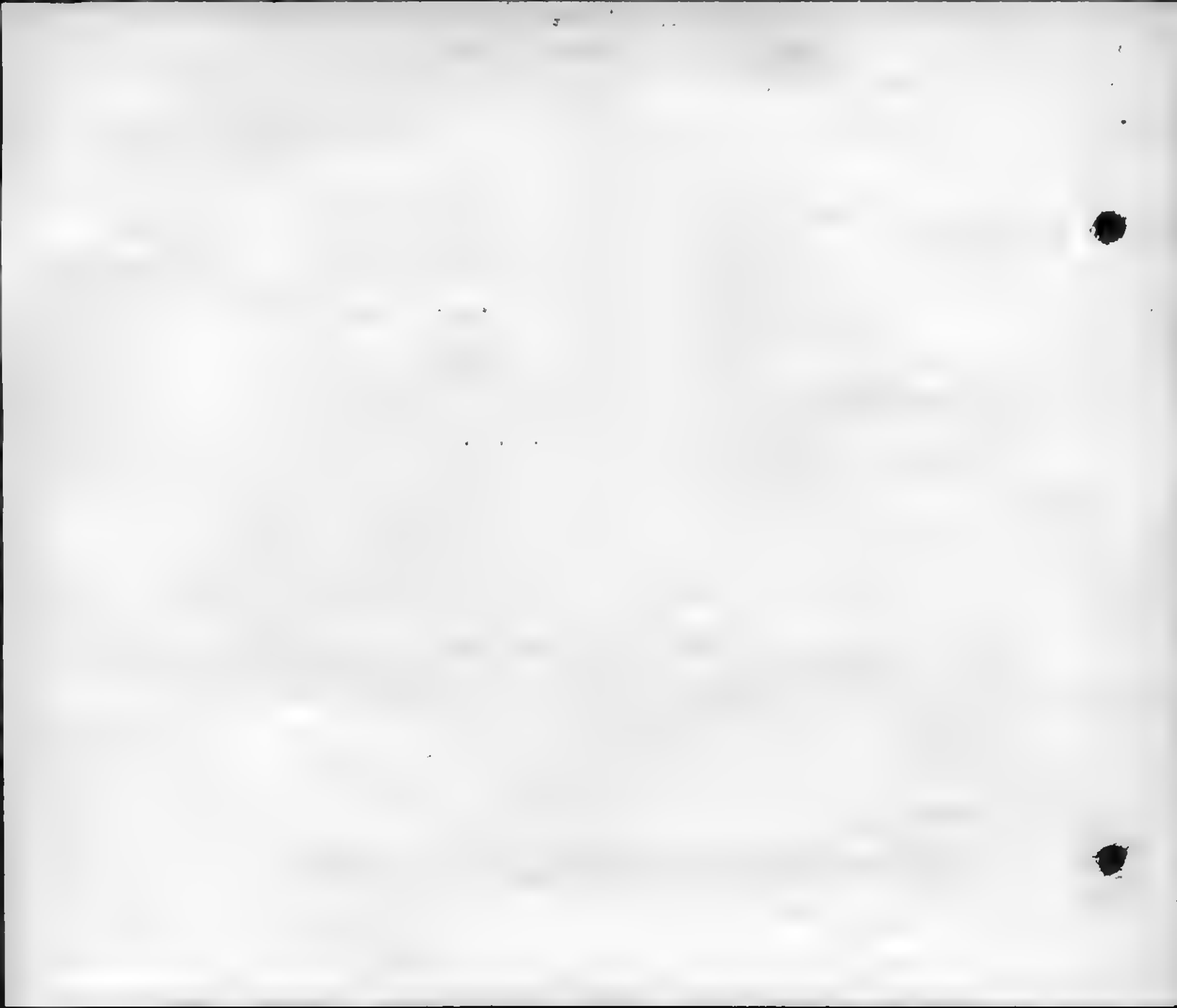
| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE CO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TEXAS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TEXAS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NONE | | d. STREET ADDRESS TEXAS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle PEACOCK Last PEACOCK | | 4. DATE OF DEATH Month JUNE Day 19 Year 19 58 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 1, 1872 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER - RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY STORE BAR | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO 219-22-2817 | |
| 17. INFORMANT Family Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Arteriosclerosis - general (c) Diabetes - mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 115X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. <input checked="" type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-1-190 to 6-19-58 , that I last saw the deceased alive on 6-17-1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Reisterstown Md DATE SIGNED 6-19-58 ACTUAL SIGNATURE James G. Saffell M.D. Reisterstown Md PHYSICIAN'S NAME (Type) James G. Saffell MD Reisterstown Md 6-19-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF JUNE 21, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY POPLAR GROVE CEMETERY | | 22d. LOCATION (City, town, or county) (State) COCKEYSVILLE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons | | 24a. REC'D BY REGISTRAR Townson 4, Md. | |
| 24b. REGISTRAR'S SIGNATURE DATE JUN 24 1958 | | | |



Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6608 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06580

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN <u>Fork</u> c. LENGTH OF STAY IN <u>7-8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION <u>Hanford Rd</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN <u>Fork</u> d. STREET ADDRESS <u>Hanford Rd</u> | | e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Edward Valentine C. Snyder</u> | | 4. DATE OF DEATH <u>6/21/58</u> | | Year <u>19</u> | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH <u>Feb 17 1904</u> | | 9. AGE (In years last birthday) <u>54 yrs</u> | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Fork Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Theodore Schneider</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Annice Traff</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO <u> </u> | |
| 17. INFORMANT <u>Mrs Jordan Fork Md</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>with congestive failure</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | 20g. (County) <u> </u> | | 20h. (State) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Frank T. Kasik</u> | | EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR.</u> | | DATE SIGNED <u>6/22/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6-26-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Christian Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Fork, Maryland</u> | | 22e. (State) <u> </u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u> </u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6598
CERTIFICATE OF DEATH

06586

Reg. Dist. No.

| | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 22 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | 2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Virginia b. COUNTY Alleghany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Covington d. STREET ADDRESS 121 Prospect Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3 NAME OF DECEASED (Type or print) First WILLIAM Middle LLOYD Last PLOTT | | | | 4. DATE OF DEATH Month June Day 18 Year 1958 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 5, 1897 | | 9. AGE (In years last birthday) 61 yrs IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | | 10b. KIND OF BUSINESS OR INDUSTRY Taxicab | | 11. BIRTHPLACE (State or foreign country) Rockbridge Co. Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME James William Plott | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Hall | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW I | | | 16. SOCIAL SECURITY NO Unknown | | 17. INFORMANT Clinical Rec., Vet. Adm. Hospital, Ft. Howard, Md. Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LIVER WITH GENERALIZED METASTASIS DUE TO LAENNEC'S CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 11 p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that VA attended the deceased from May 27 , 19 58 , to June 18 , 19 58 , and that death occurred at 2:45 P. M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Donald D. Mark</i> M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 6/19/58 PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D. | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6-19-58 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Covington, Virginia | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook - Blight Inc.</i> Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. 14, Md. | | | | 24a. REC'D BY REGISTRAR JUN 23 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Riches</i> | | | |

To: R.M. Loving Funeral Home, Maple & Riverside Ave., Covington, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 D
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

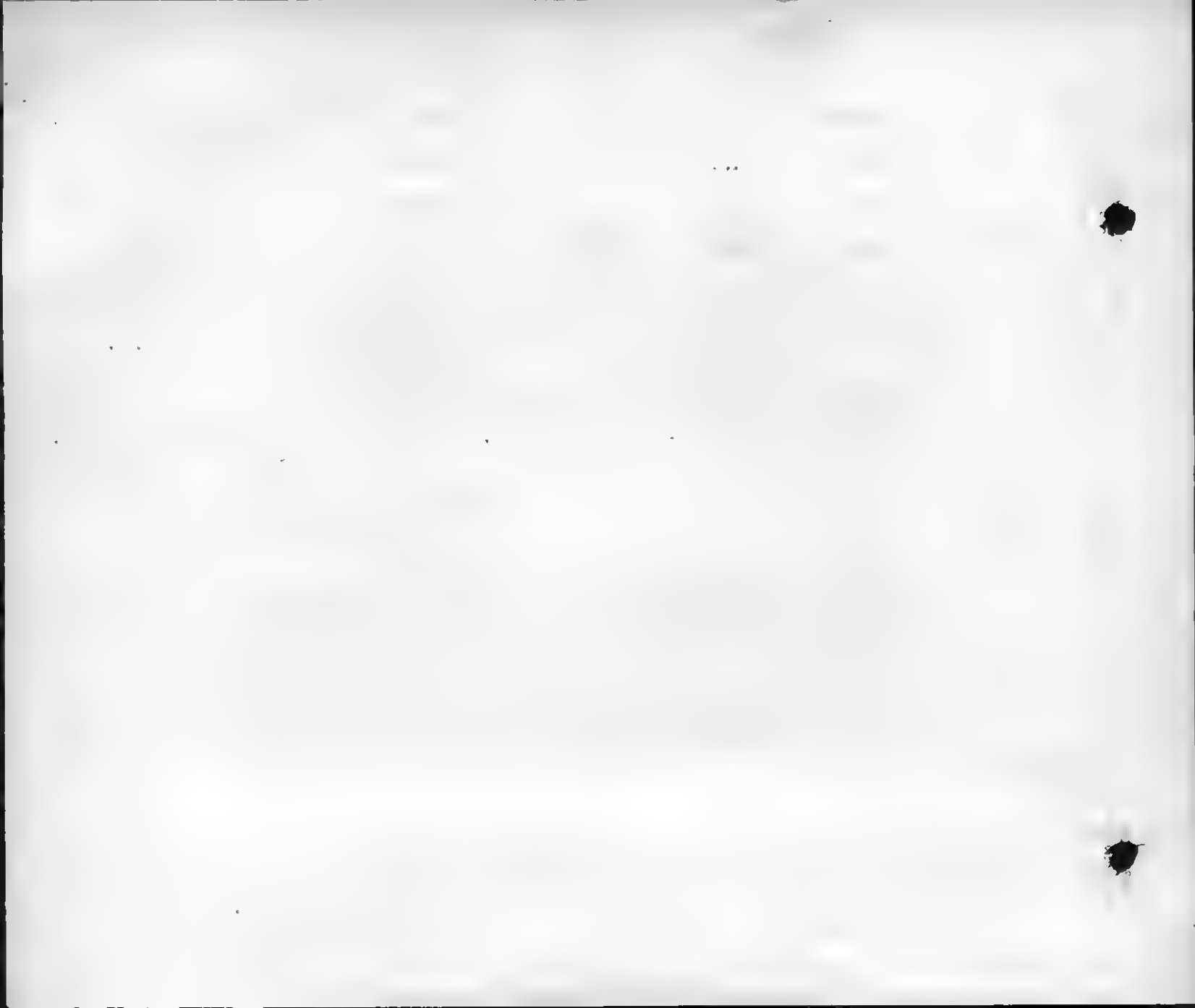
6599

CERTIFICATE OF DEATH

06587

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|-----------------------------------|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall | | | | c. LENGTH OF STAY IN 1b 5 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Vernon Henry Purkey | | | | 4. DATE OF DEATH Month Day Year 6-5-58 19 | | | |
| 5 SEX male | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 5-26- 1893 | | 9 AGE (In years last birthday) 65 yrs | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mining | | 10b. KIND OF BUSINESS OR INDUSTRY mine | | 11 BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Dock Franklin Purkey | | | | 14 MOTHER'S MAIDEN NAME Lucinda Cox | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16 SOCIAL SECURITY NO. WWI 1918-19, 401-01-8265 | | 17 INFORMANT Address Mrs. Vernon Purkey, White Hall, Md. | | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH one hour | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1953 to June 4, 1958 that I last saw the deceased alive on June 4, 1958 , and that death occurred at 11:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) White Hall, Md. DATE SIGNED William E. Bortner | | | | | | | |
| ACTUAL SIGNATURE William E. Bortner | | | | M.D. White Hall, Md. | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6-6-58 | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) Pound, Va. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE William E. Bortner ADDRESS 1557 North Ave. Baltimore 12, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 6 '58 | | 24b. REGISTRAR'S SIGNATURE Albert | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6600

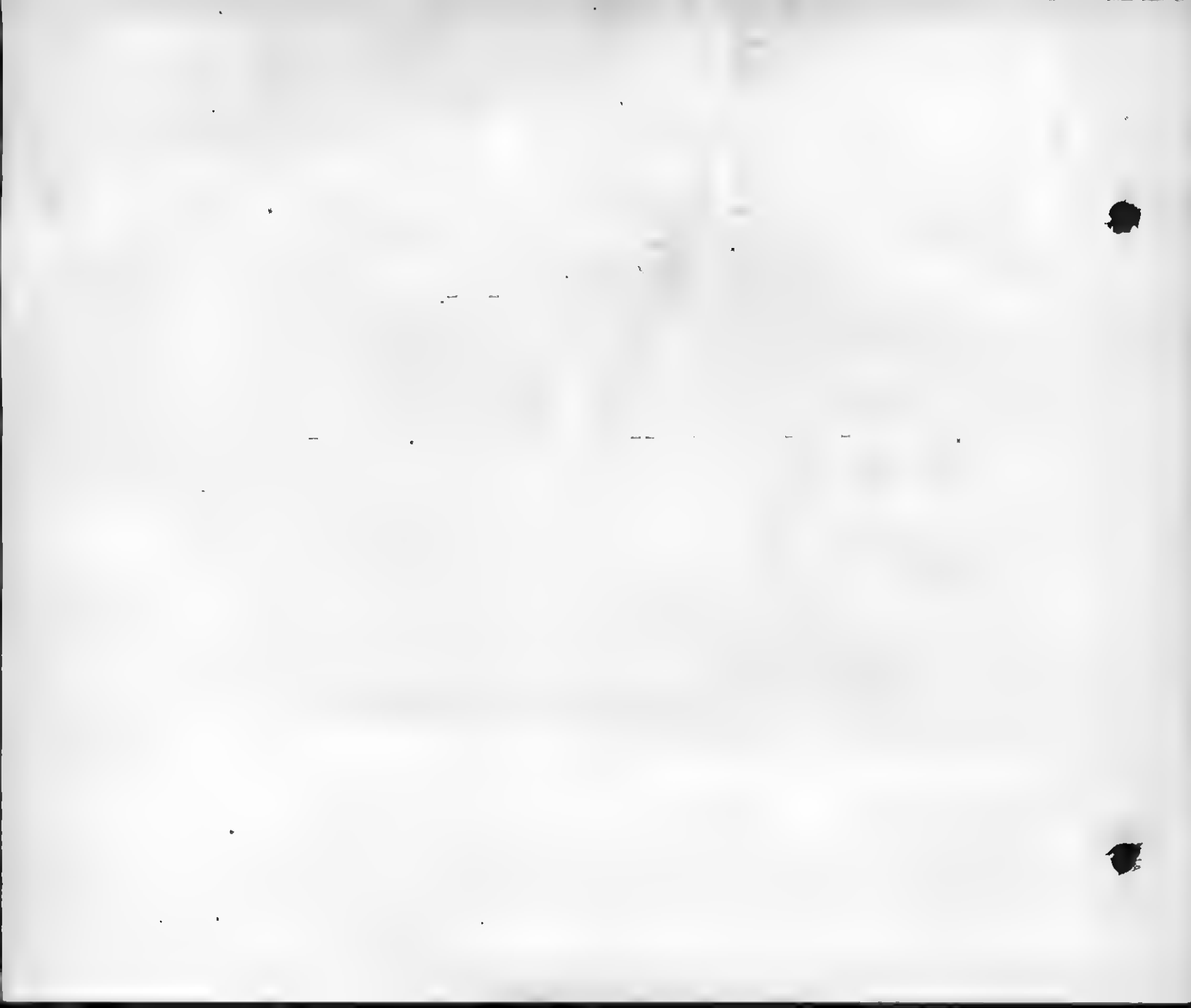
CERTIFICATE OF DEATH

Reg. Dist. No.

00588

| | | | |
|---|------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Catonsville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forrest Haven-Nursing Home | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 637 Frederick Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Margaret E. Ripley | | 4 DATE OF DEATH Month June Day 3 Year 1958 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 10-19-1875 |
| 9 AGE (In years last birthday) 82 yrs | | IF UNDER 1 YEAR Months Days Hours M.in. | IF UNDER 24 HRS Months Days Hours M.in. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY At home | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Henry Ripley | | 14. MOTHER'S MAIDEN NAME Mary Shaffer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No. | | 16 SOCIAL SECURITY NO --- | |
| 17 INFORMANT Frederick L. Ripley | | Address 136 Willard Street | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR DISEASE DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO DISEASE (c) DISEASE | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/1 , 19 58 , to 6/3 , 19 58 , that I last saw the deceased alive on 6/2 , 19 58 , and that death occurred at 5:41 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5800 Edmondson Ave. DATE SIGNED 6/4/58 | | | |
| ACTUAL SIGNATURE John H. Shaw M.D. | | PHYSICIAN'S NAME (Type) John H. Shaw M.D. BALD. 28, MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b DATE THEREOF June 5-1958 | |
| 22c NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery | | 22d. LOCATION (City, town, or county) (State) Old Court Rd. Maryland | |
| 23 FUNERAL DIRECTOR'S SIGNATURE F. D. Kippert ADDRESS 1300 Eutaw Place | | 24a REC'D BY REGISTRAR JUN 6 '58 24b REGISTRAR'S SIGNATURE W. J. Adams | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

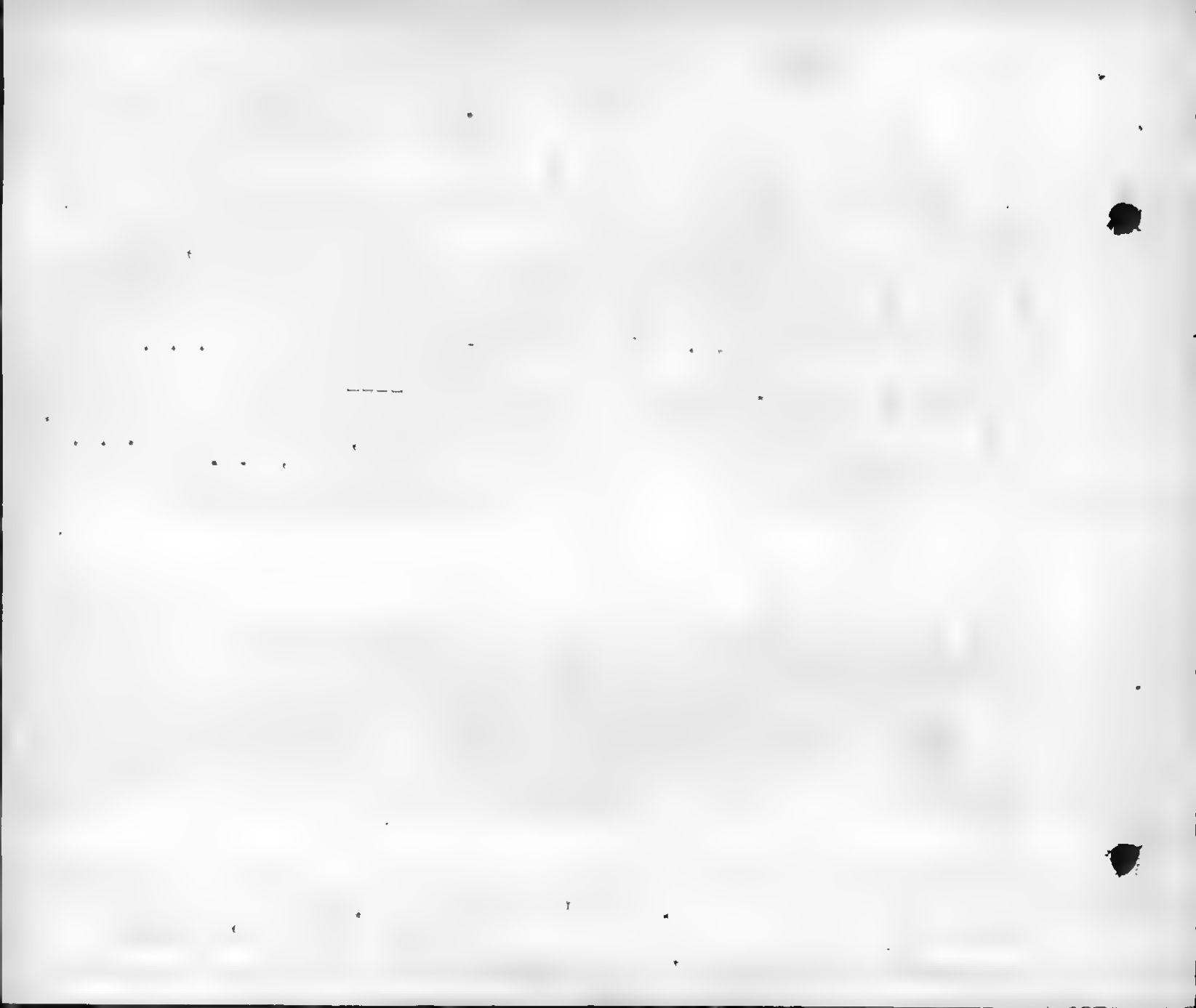
CERTIFICATE OF DEATH

06589

6601

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 636 North Bend Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Thomas Rooney | | | 4. DATE OF DEATH Month June Day 19 Year 1958 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 9, 1903 | | 9. AGE (In years last birthday) 54 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | IF UNDER 24 HRS. Hours 0 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Social Security- | | 11. BIRTHPLACE (State or foreign country) Kentucky | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME late Michael J. Rooney | | | | 14. MOTHER'S MAIDEN NAME late Mary---- | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Miss Laura Rooney, 2800 Ontario Rd. N.W. 401 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE & ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH 2 YRS + | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from JAN 1956 to 6/19 1958 , that I last saw the deceased alive on 6/18 1958 , and that death occurred at 1 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Thos E Roach | | | | ADDRESS (Street, city or town, state) DATE SIGNED 3629 Edmondson Ave 6/20/58 | | | |
| PHYSICIAN'S NAME (Type) Thos E Roach | | | | Baltimore - 29 - Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF June 21/58 | | 22c. NAME OF CEMETERY OR CREMATORY St. Thomas' Cemetery | | 22d. LOCATION (City, town, or county) (State) Mt. Sterling Kentucky | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave | | | | 24a. REC'D BY REGISTRAR June 24 58 | | 24b. REGISTRAR'S SIGNATURE Witzke | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

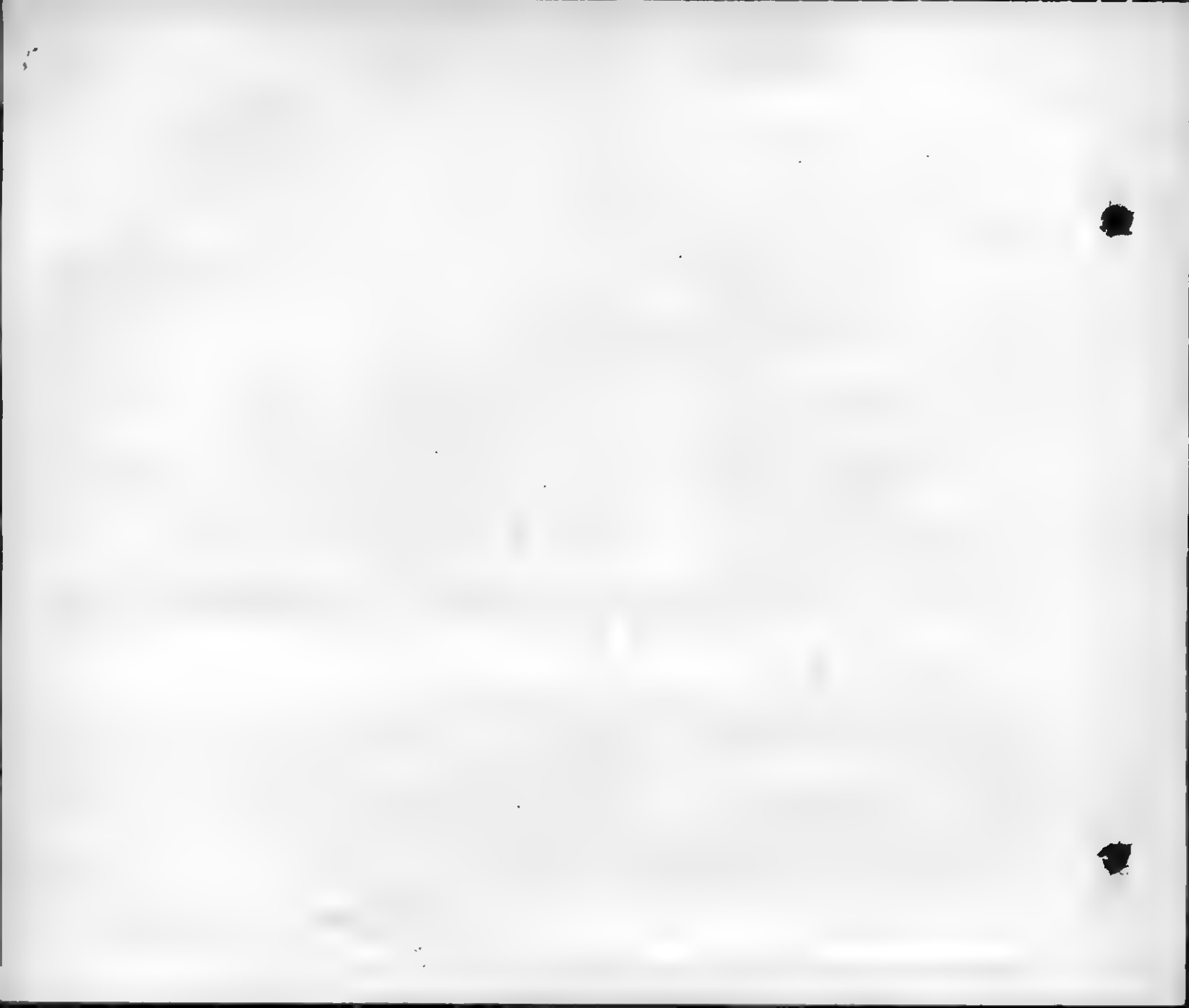
06590

6602

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> | | c. LENGTH OF STAY IN 1b <u>50yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u> | | | | d. STREET ADDRESS <u>Old York Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>B.</u> Last <u>Rasier</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 13 1890</u> | 9. AGE (In years last birthday) <u>67</u> yrs. | IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> | IF UNDER 24 HRS Hours <u>6</u> Min. <u>13</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ownhome</u> | | 11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jonathan Baker</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hester Horseman</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-360079</u> | | 17. INFORMANT <u>Dr. Herbert Rasier, Parkton Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>5yrs.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>6-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>58</u> , and that death occurred at <u>11:00 P.M.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>New Freedom York Co. Pa.</u> DATE SIGNED <u>6/21/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Louis Schatanoff</u> | | | | PHYSICIAN'S NAME (Type) <u>LOUIS SCHATANOFF, M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 23 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>New Freedom Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Hartenstein</u> | | | | ADDRESS <u>New Freedom, Pa.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur</u> | | | |



6603

CERTIFICATE OF DEATH

Reg. Dist. No.

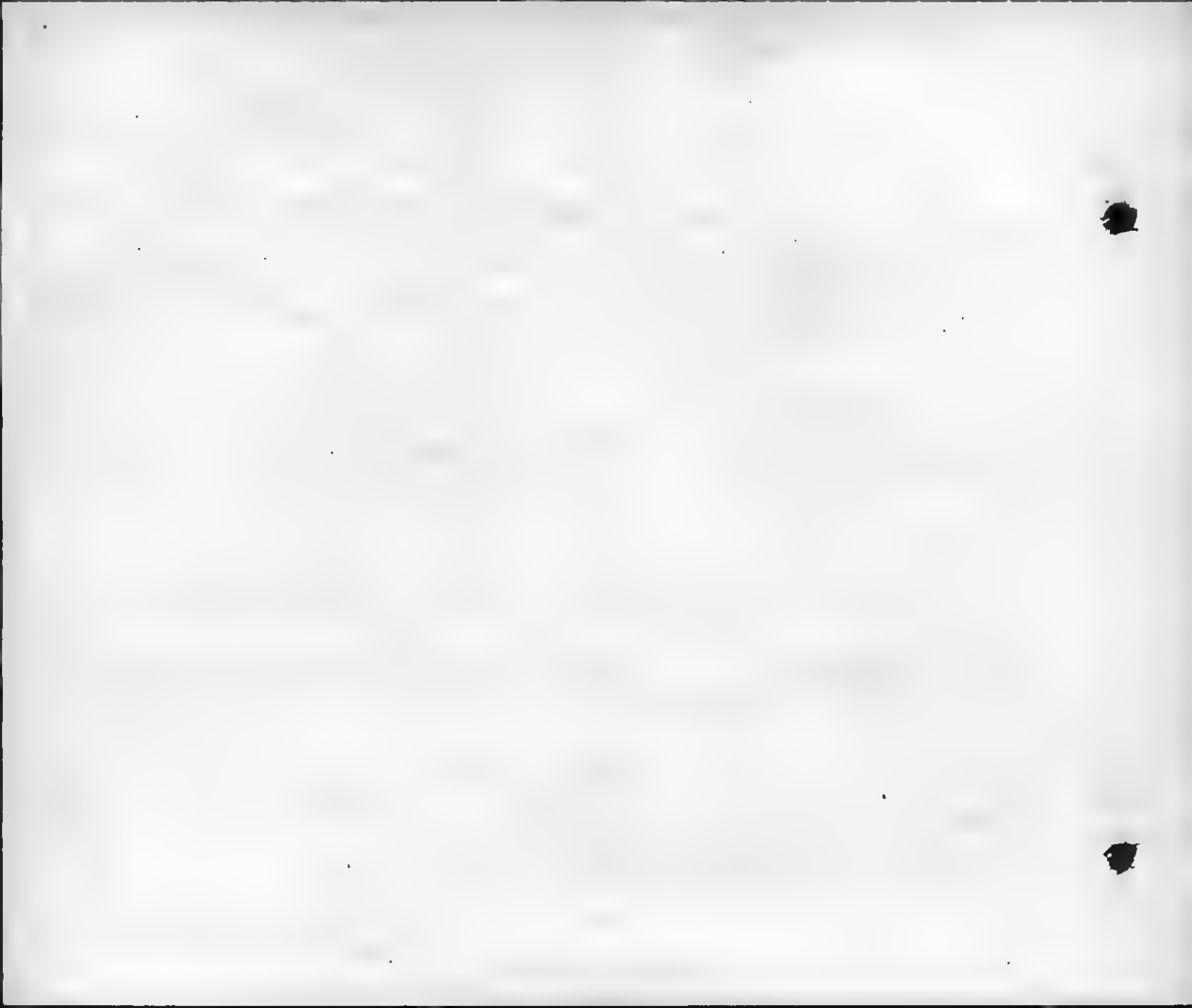
| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE md. b. COUNTY Balto | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 10 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 647 North Bend Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOSEPH GEORGE ROTH First Middle Last | | 4. DATE OF DEATH June 26 1958 Month Day Year | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB-7-1891 AGE (In years last birthday) 67 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supr | | 10b. KIND OF BUSINESS OR INDUSTRY Hutzel Bros Phila Pa | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles Roth | | 14. MOTHER'S MAIDEN NAME Amelia Stumpner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) Yes | | 16. SOCIAL SECURITY NO 14-01-0861 | |
| 17. INFORMANT Caroline E. Roth Address 647 North Bend Rd | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 6 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-7-1957 to 6-26-1958 , that I last saw the deceased alive on 6/13-1958 , and that death occurred at 3 A M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE H. W. Scheve M.D. | | ADDRESS (Street, city or town, state) 3921 EDMONDSON BALTO 29 MD. DATE SIGNED 6/26/58 | |
| PHYSICIAN'S NAME (Type) H. W. SCHEVE M.D. | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | June 30, 1958 | New National Cem | Balto Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE John F. Pough ADDRESS 5311 Edmondson Ave | | 24a. REC'D BY REGISTRAR JUN 30 '58 DATE 24b. REGISTRAR'S SIGNATURE W. H. Hedrick | |

MEDICAL CERTIFICATION

6-54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6604

CERTIFICATE OF DEATH

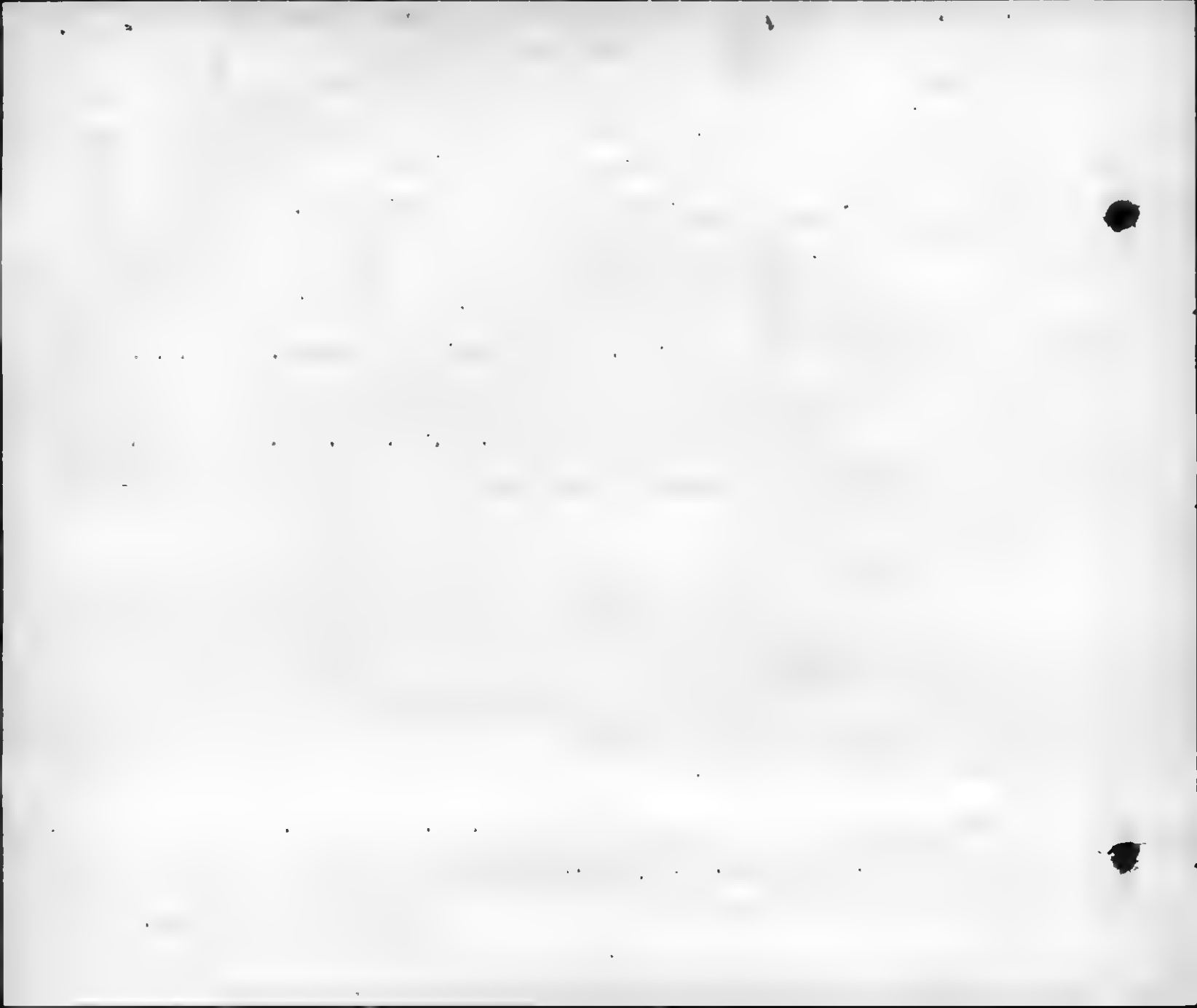
06592

Reg. Dist. No.

| | | | |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 54 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 4002 Mortimer Ave., | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter (NMI) ROTH | | 4. DATE OF DEATH Month Day Year June 7 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 10, 1890 |
| 9. AGE (In years last birthday) 67 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY Hauling. | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John William Roth | | 14. MOTHER'S MAIDEN NAME Elizabeth Petty | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 212-12-1191 | |
| 17. INFORMANT ClinRec.Vet.Adm.Hosp., Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER OF THE BLADDER 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 8 Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 14, 19 58 to June 7, 19 58 and that death occurred at 3:20A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH. FT. HOWARD, MD. June 7, 1958 | | | |
| ACTUAL SIGNATURE  | | M.D. VAH. FT. HOWARD, MD. | |
| PHYSICIAN'S NAME (Type) Dr. Garfield D. KINGTON, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-10-58 | 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge, | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook - Blight | | 24a. REC'D BY REGISTRAR JUN 9 58 | 24b. REGISTRAR'S SIGNATURE  |
| ADDRESS William Cook-Blight, 6009 Harford Rd, Baltimore, Md. | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6605

CERTIFICATE OF DEATH

06593

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>ROSEWOOD BALTO. CO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILL</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE CITY</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING School</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SAMUEL Joseph SALKIN</u> | | 4. DATE OF DEATH Month Day Year <u>6 21 1958</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/7/14</u> |
| 9. AGE (In years last birthday) <u>43</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>MORRIS BURK SALKIN</u> | |
| 14. MOTHER'S MAIDEN NAME <u>LENA SCHARLEW SALKIN</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT Address <u>ROSEWOOD RECORDS</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Pneumonia with infection</u> DUE TO (c) <u>Traction of the bone (chest)</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 26, 1957</u> to <u>June 21, 1958</u> that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>St. S. Butler</u> M.D. | | ADDRESS (Street, city or town, State) <u>Quarrys Mills, Md</u> DATE SIGNED <u>6/21/58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>6-22-58</u> | <u>Hebrew Young men</u> | <u>Balto Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc</u> ADDRESS <u>2100 Butaw Pl</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 23 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6606

CERTIFICATE OF DEATH

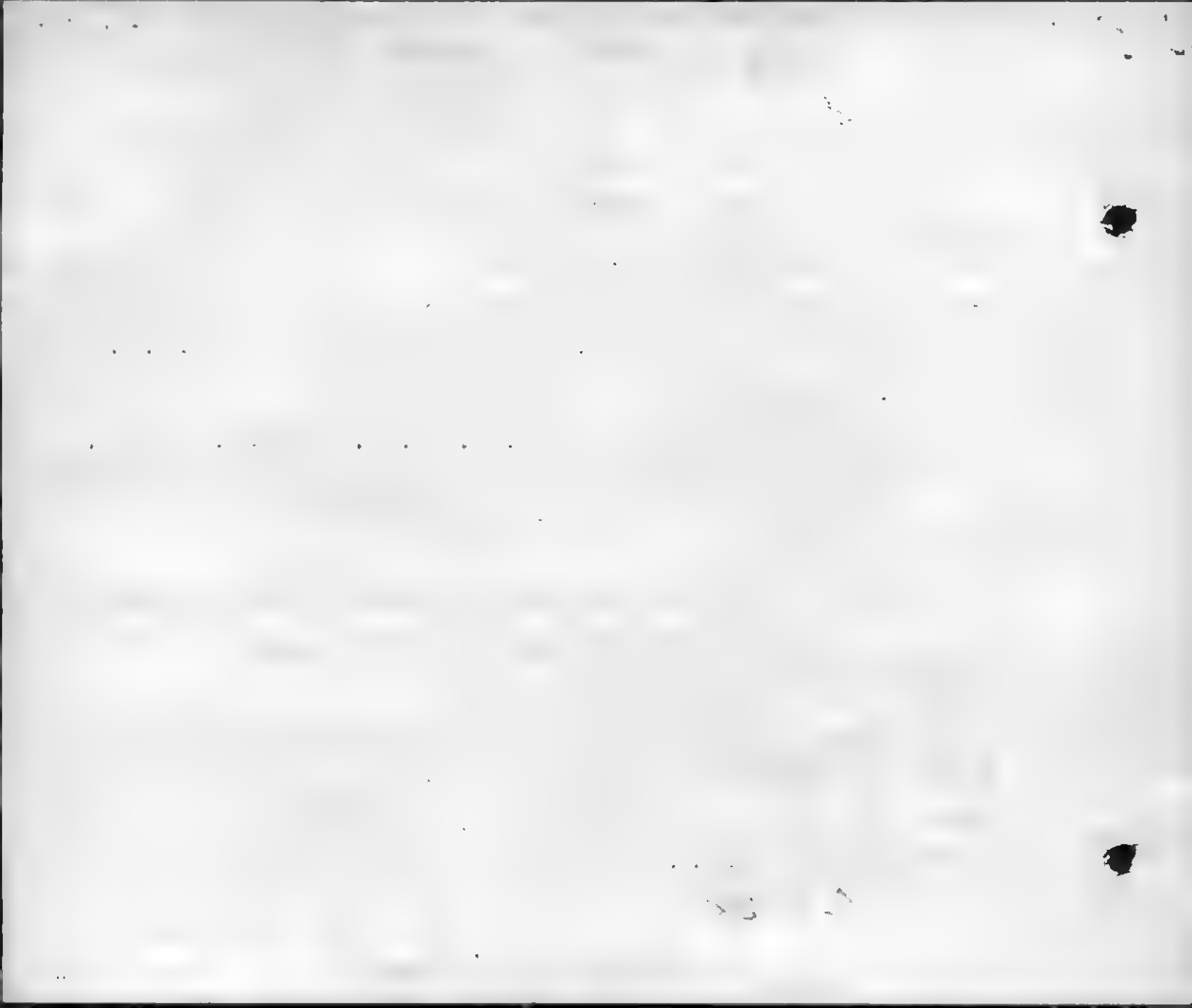
Reg. Dist. No.

06594

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 19 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| f. STREET ADDRESS 1907 Wheeler Avenue | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First THEODORE Middle R. Last SAUNDERS | | 4. DATE OF DEATH Month June Day 25 Year 1958 | |
| 5 SEX Male | 6. COLOR OR RACE Colored | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH August 12, 1906 |
| 9. AGE (In years last birthday) 51 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Building Construction) | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William H. Saunders | | 14. MOTHER'S MAIDEN NAME Pearl Wright | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO WW II 217-07-5222 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS TO PORTA HEPATICUS, LIVER, AND ABDOMINAL WALL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 1 YEAR |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 6, 1958 to June 25, 1958 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Chien Wei Lan</i> | | DATE SIGNED 6/25/58 | |
| PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-30-58 | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders | | 24. REC'D BY REGISTRAR DATE 6-26-58 | |
| ADDRESS 217 E. Preston St. Baltimore, Maryland | | 25. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

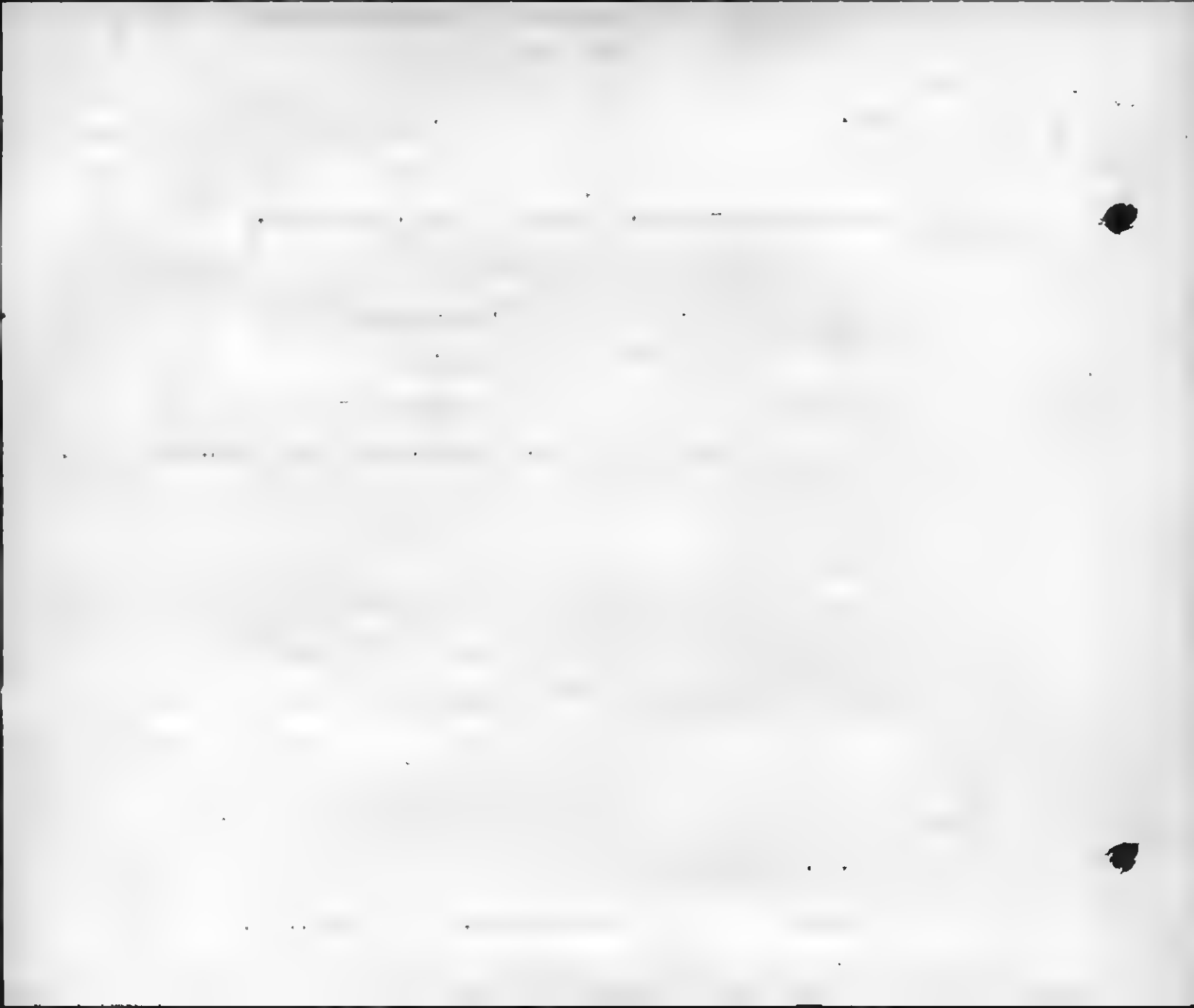
6607

CERTIFICATE OF DEATH

06595

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|--|--|--------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Balto. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home-1002 N. Rolling Rd. | | | | d. STREET ADDRESS 617 N. Denison St. | | | |
| 3 NAME OF DECEASED (Type or print) First CATHERINE Middle D. Last SCHAEFER | | | | 4. DATE OF DEATH Month June Day 27 Year 19 58 | | | |
| 5 SEX female | 6. COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 3, 1885 | 9. AGE (In years last birthday) 72 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Md. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME Michael Fitzpatrick | | | | 14 MOTHER'S MAIDEN NAME Elizabeth - | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17 INFORMANT Mr. Robert T. Schaefer - 617 N. Denison St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Carcinoma of Ovary DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 1956 to June 27, 1958 , that I last saw the deceased alive on June 26, 1958 , and that death occurred at 9:12 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE D. C. MacLaughlin | | | | ADDRESS (Street, city or town, state) Md. 4508 Edmondson Village | | DATE SIGNED 6/28/58 | |
| PHYSICIAN'S NAME (Type) D. C. MacLaughlin | | | | | | | |
| 22a BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/1/58 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fisher & Sons - Balto 17 | | | | 24a. REC'D BY REGISTRAR DATE JUN 30 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

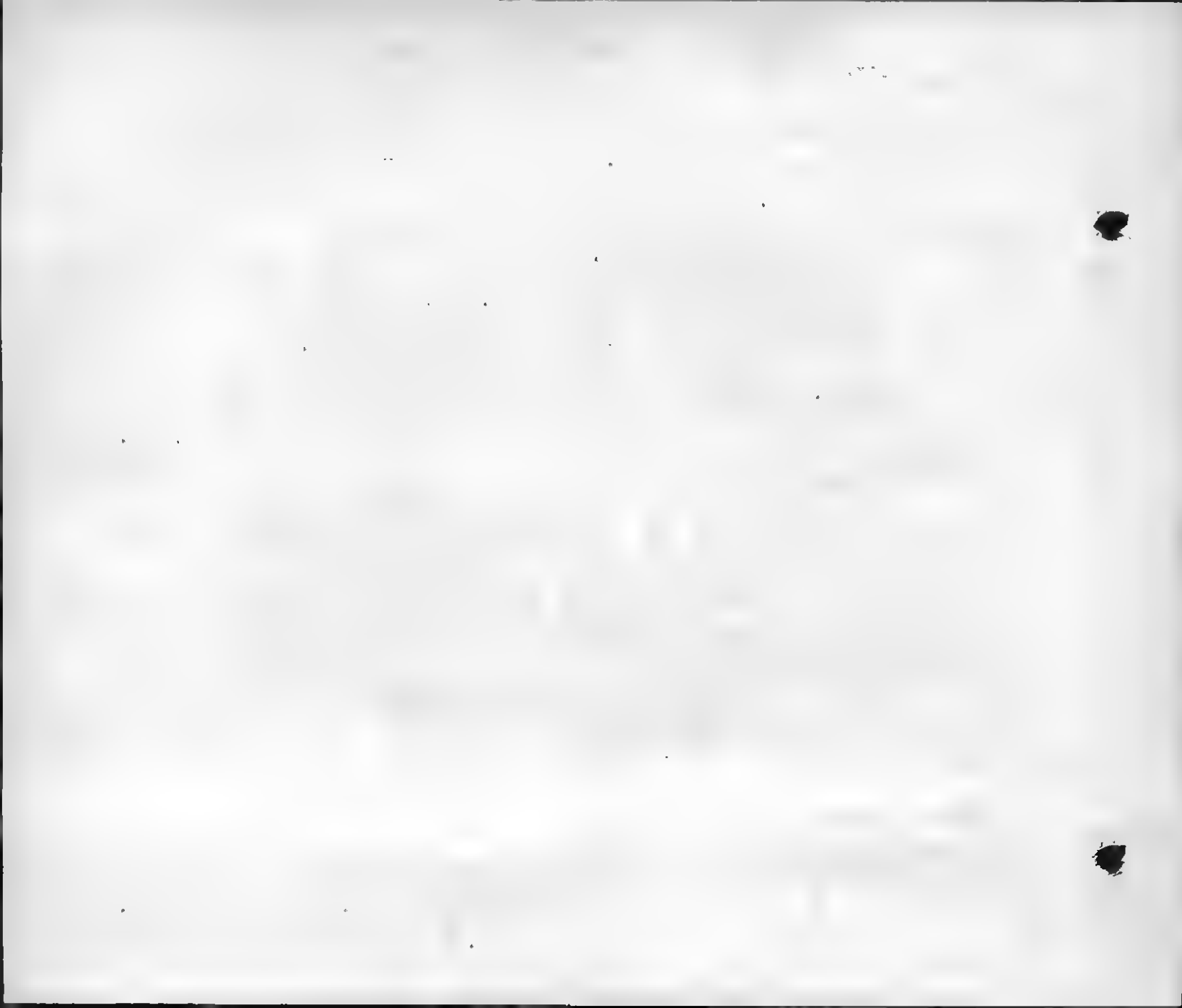
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6609

CERTIFICATE OF DEATH

Reg. Dist. No. 06596

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. LENGTH OF STAY IN 1b <u>3 mo.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Newburg Ave.</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Etchison</u> | | | |
| | | | | d. STREET ADDRESS <u>RFD # 2 Woodbine</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ALMEDA</u> Middle <u>S.</u> Last <u>SHEFFER</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Feb. 15, 1872</u> | |
| 9. AGE (In years last birthday) <u>86</u> yrs | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>New Market, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Oliver P. Snyder</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Mary Hilton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mrs James Hilton, Woodbine, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>440.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Advanced arterio-sclerosis</u> DUE TO <u> </u> (c) <u> </u> | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u> <u>Year</u> | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>My Sengrene Rt. foot - Thrombophlebitis</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 10, 1958</u> to <u>June 34, 1958</u> that I last saw the deceased alive on <u>June 23, 1958</u> and that death occurred at <u>7-8 P</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wetherbee Fort</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>6 Wetherbee Ave</u> | | | |
| DATE SIGNED | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 26, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Nr. Cooksville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molsaunth</u> | | | | ADDRESS <u>Damascus, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Alf Beach</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6610

CERTIFICATE OF DEATH

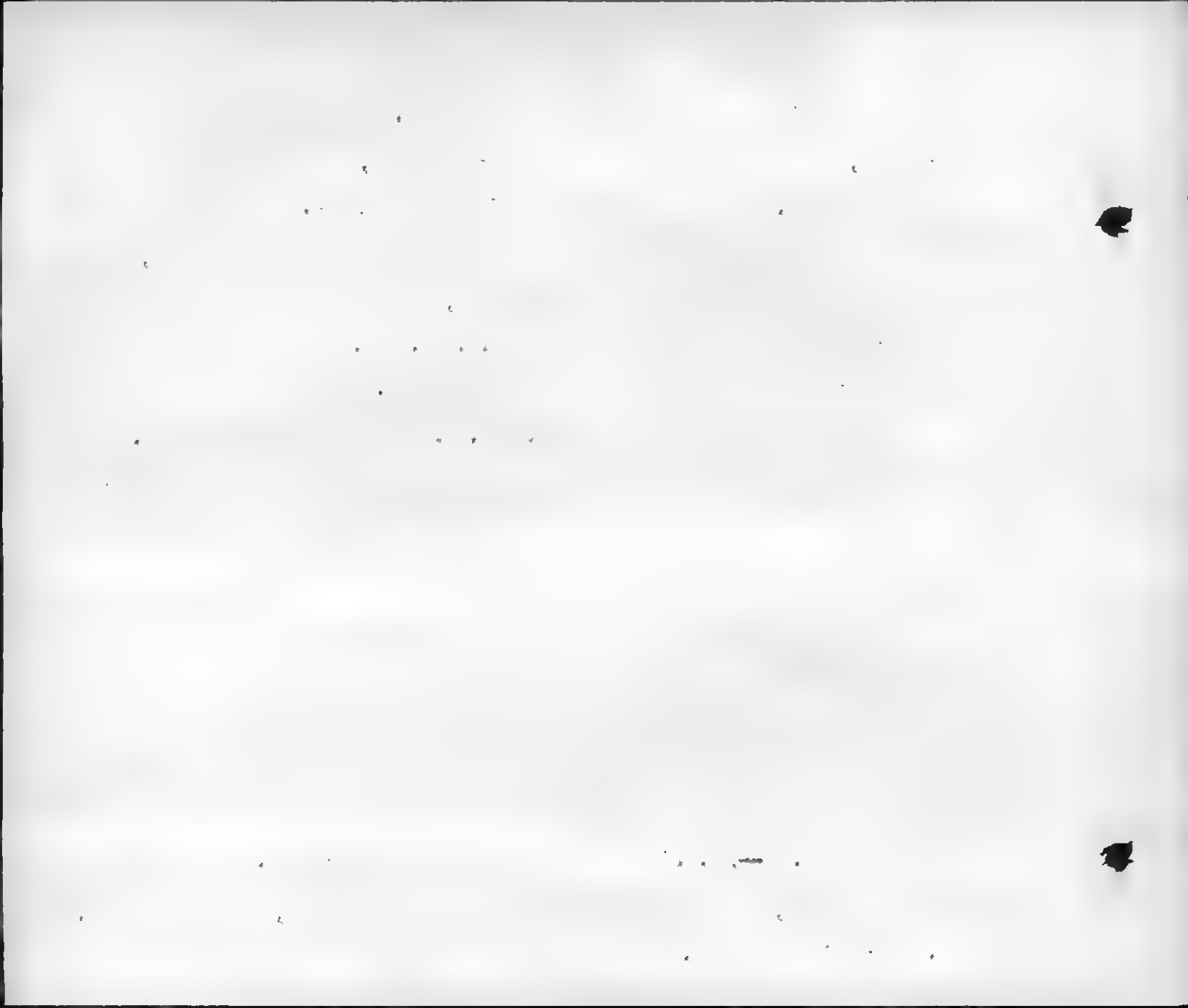
Reg. Dist. No.

06597

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, | | c. LENGTH OF STAY IN 1b Catonsville, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Rosewood Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Iva Middle Carr Last Shipley | | 4. DATE OF DEATH Month June Day 13 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 12, 1888 |
| 9. AGE (In years last birthday) 70 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) A.A. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY | |
| 13. FATHER'S NAME Cheever Carr | | 14. MOTHER'S MAIDEN NAME Florence O. Turner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Geo. L. Wehland 111 Rosewood Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage 443X DUE TO (b) HTCVD + ASCVD Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) (Pt under care of Dr. T. Herbert-Elliott City) | | INTERVAL BETWEEN ONSET AND DEATH 1 hr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Previous CVA 6 wks ago - Pneumonia 2 days | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/13, 1958 to 6/17, 1958 , that I last saw the deceased alive on 6/17, 1958 , and that death occurred at 12:20 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Victor F. Keen M.D. | | ADDRESS (Street, city or town, state) 715 Frederick Ave DATE SIGNED 6/13/58 | |
| PHYSICIAN'S NAME (Type) Victor F. Keen M.D. | | 715 Frederick Ave. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 16, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Green Mount | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place | | 24a. REC'D BY REGISTRAR JUN 16 '58 | |
| 24b. REGISTRAR'S SIGNATURE Attended | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

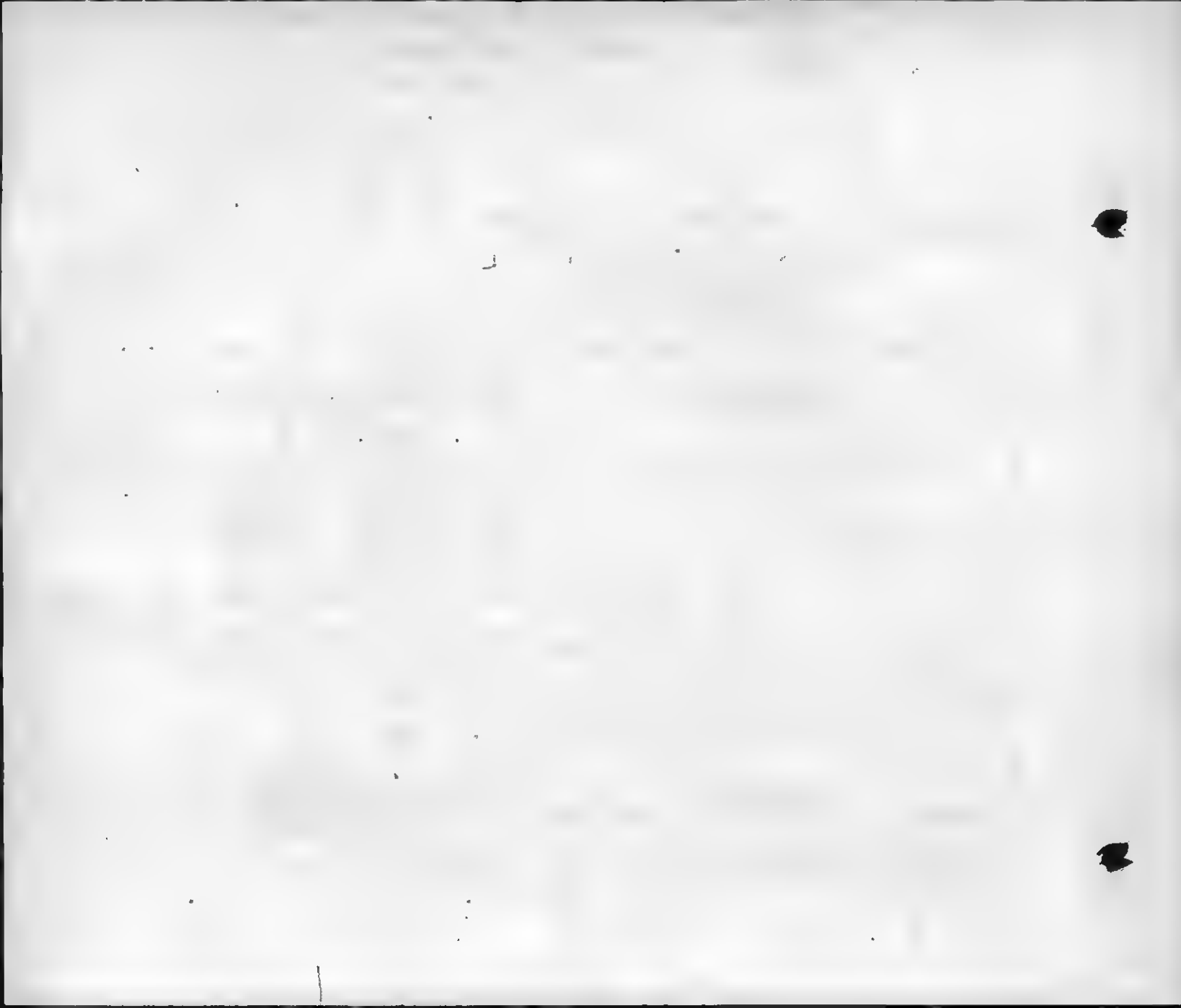
CERTIFICATE OF DEATH

6611

Reg. Dist. No. 06598

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 301 Eastern Blvd. | | | |
| 3. NAME OF DECEASED (Type or print) MARY GOLDIE SLADE | | | | 4. DATE OF DEATH June 19 1958 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH June 30, 1890 | |
| 9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. AGE (in years last birthday) 67 yrs. | | 11. IF UNDER 1 YEAR Months Days Hours Min | | 12. IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Baltimore County, Md | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | 13. FATHER'S NAME Stanley Slade | | | |
| 14. MOTHER'S MAIDEN NAME Sarah A. Tinkler | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Elmer P. Slade, above | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary Anaemia DUE TO Curcinoma Transverse Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 yrs DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1, 1956 to June 19, 1958 that I last saw the deceased alive on June 18, 1958 and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GMBarringardner Balto 6 Md. DATE SIGNED 6/19/58 | | | | | | | |
| ACTUAL SIGNATURE | | | | PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 6/23/58 | | Loudon Park Cem. | | Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane | | | | 24a. REC'D BY REGISTRAR DATE JUN 23 58 | | 24b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6481

CERTIFICATE OF DEATH

06599

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALETHROPE | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALETHROPE | | | |
| c. LENGTH OF STAY IN 1b 2 MOS | | | | d. STREET ADDRESS 2030 Northeast Ave | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2030 Northeast Ave | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First ELLA Middle GRMEN Last SMART | | | | 4. DATE OF DEATH Month JUNE Day 20 Year 1958 | | | |
| 5. SEX F | | 6. COLOR OR RACE Col. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-4-93 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR: Months 6 Days 15 Hours 15 Min 15 | | IF UNDER 24 HRS: Months 0 Days 0 Hours 0 Min 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Georgia | | 11. BIRTHPLACE (State or foreign country) U.S.A. | |
| 13. FATHER'S NAME William Coleman | | | | 14. MOTHER'S MAIDEN NAME Clara | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No. | | 16. SOCIAL SECURITY NO. No. | | 17. INFORMANT John H. Griner, Sr. Address 2030 Northeast Ave | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hepatitis DUE TO Carcinoma of Stomach Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unknown DUE TO (c) Unknown INTERVAL BETWEEN ONSET AND DEATH Several weeks | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from MAY 19, 1958 , to JUNE 20, 1958 , that I last saw the deceased alive on JUNE 19, 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Richard H. Hunt M.D. 1607 W. Mulberry St. | | | | DATE SIGNED 6-23-58 | | | |
| PRINTED NAME (Type) RICHARD H. HUNT | | | | 1607 W. Mulberry St. MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-24-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | | 22d. LOCATION (City, town, or county) (State) Cedar Hill Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Clayton Wilson ADDRESS 1000 | | | | 24a. REC'D BY REGISTRAR JUN 27 1958 | | 24b. REGISTRAR'S SIGNATURE John H. Griner | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6482

CERTIFICATE OF DEATH

Reg. Dist. No.

06600

| | | | |
|---|---------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1241 Leeds Terrace | | d. STREET ADDRESS 1241 Leeds Terrace | |
| 3 NAME OF DECEASED (Type or print) First Middle Last C. HERBERT SMITH | | 4. DATE OF DEATH Month Day Year June 5, 1958 | |
| 5 SEX male | 6 COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 14, 1892 |
| 9. AGE (In years last birthday) 65 yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b KIND OF BUSINESS OR INDUSTRY Paint | |
| 11 BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George Smith | | 14 MOTHER'S MAIDEN NAME Minnie Cline | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I | | 16. SOCIAL SECURITY NO | |
| 17 INFORMANT Mrs. Rose M. Smith - 1241 Leeds Ave. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) Generalized A.S.C.V.D. | | INTERVAL BETWEEN ONSET AND DEATH 6 wks. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 1955 to June 5, 1958 , that I last saw the deceased alive on May 30, 1958 and that death occurred at 7:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 6/6/58 | | | |
| ACTUAL SIGNATURE John C. Healy | | PHYSICIAN'S NAME (Type) John C. Healy | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/7/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cen. | | 22d. LOCATION (City, town or county) (State) Balto., Md. | |
| 23 FUNERAL DIRECTOR'S SIGNATURE Mr. J. J. Baker & Sons - Balto 17 | | 24a. REC'D BY REGISTRAR DATE JUN 6 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. H. Beach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6612

CERTIFICATE OF DEATH

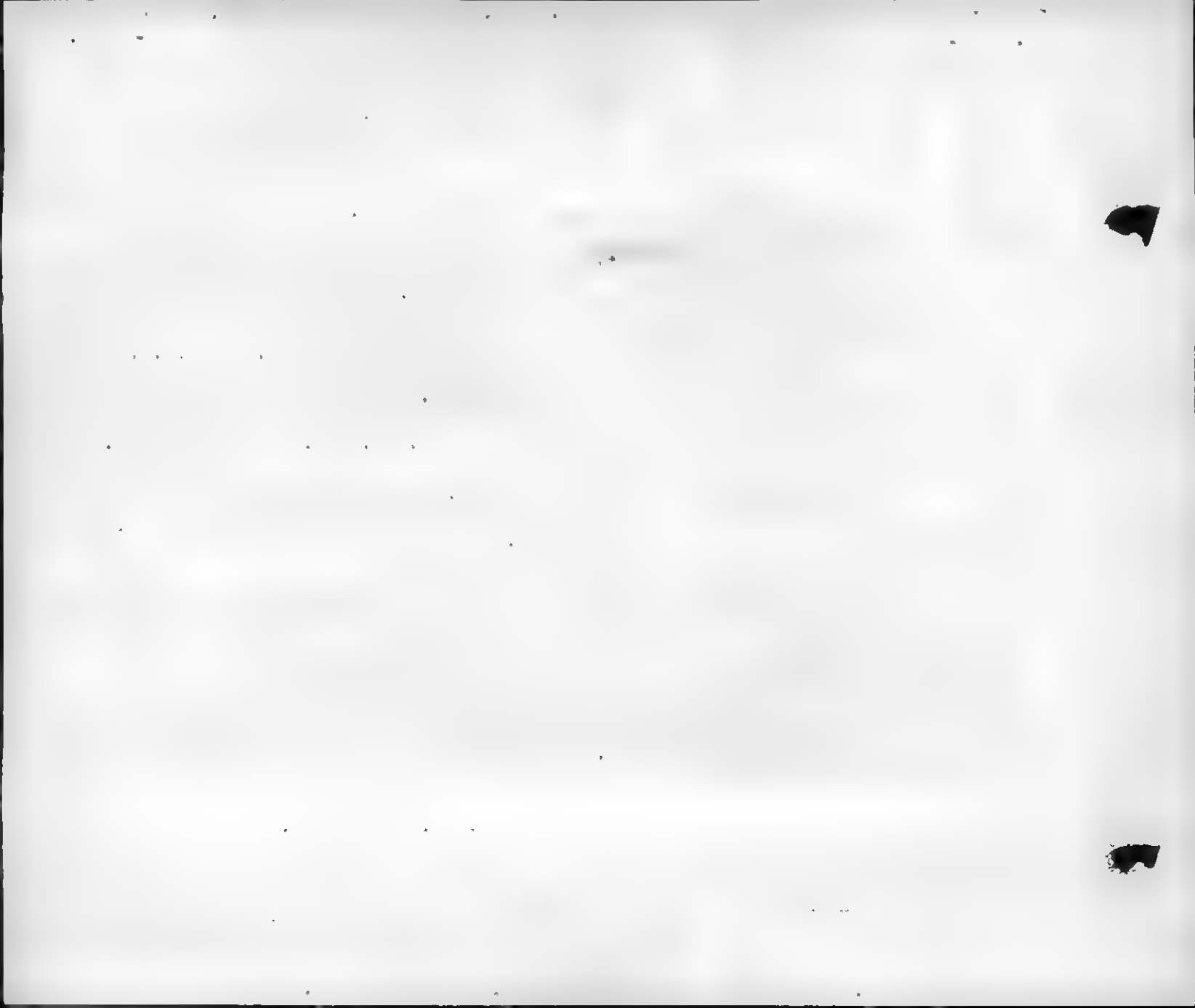
Reg. Dist. No.

06601

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 217 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 840 Pierce St., | |
| 3. NAME OF DECEASED (Type or print) (Served as Clinton Johnson) First Middle Last Clinton J. SMITH | | 4. DATE OF DEATH Month Day Year June 6 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 22, 1889 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Brewery | |
| 11. BIRTHPLACE (State or foreign country) Westminster, Maryland. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Thomas Smith | | 14. MOTHER'S MAIDEN NAME Alice F. Johnson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. 218-10-1021 | |
| 17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT AND LEFT. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) PULMONARY CONGESTION. DUE TO (c) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE. Interval between onset and death 2 days 2 days Unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-93x | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 1 19 57 to June 6 19 58 , that I last saw the deceased live and that death occurred at 10:00 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6/7/58 | | | |
| ACTUAL SIGNATURE Charles T. Fitch | | M.D. VAH. ET. HOWARD, MD. | |
| PHYSICIAN'S NAME (Type) CHARLES T FITCH | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-11-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | 24a. REC'D BY REGISTRAR JUN 10 '58 | |
| ADDRESS 802 Madison | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

Charles R. Law Mortuary, 802 Madison Ave., Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6613

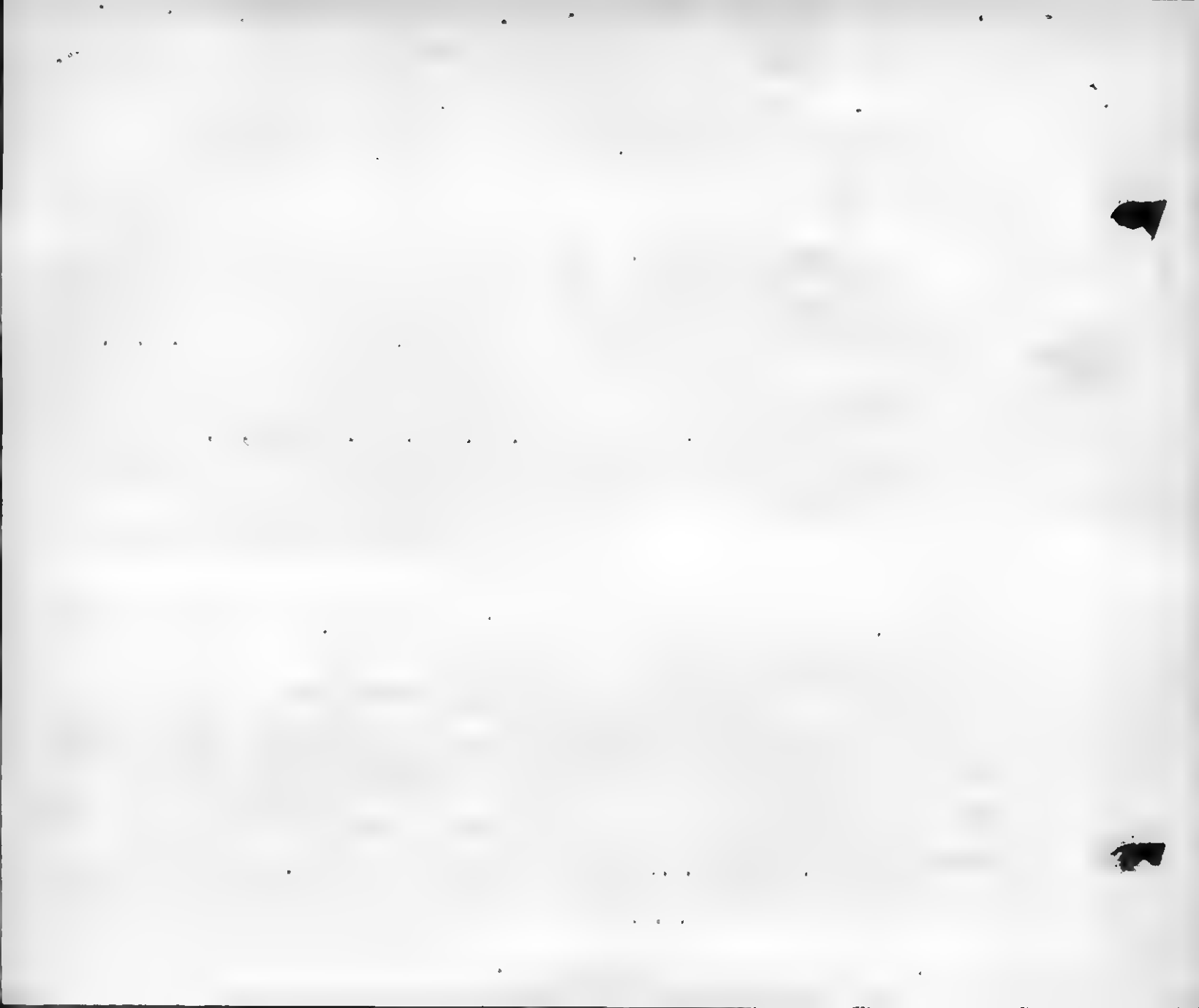
CERTIFICATE OF DEATH

06602

Reg. Dist. No.

| | | | |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenmount | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS Box 38 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle D. Last SMITH | | 4. DATE OF DEATH Month June Day 6 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 19, 1924 |
| 9. AGE (In years last birthday) yrs 34 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver | | 10b. KIND OF BUSINESS OR INDUSTRY School Bus | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Horace Smith | | 14. MOTHER'S MAIDEN NAME Elizabeth Sterner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 219-18-6586 | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: 237X IMMEDIATE CAUSE (a) BRAIN TUMOR DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Myositis Ossificans Dorsalis spinis Muscles. Operations 6/5/58, Bilateral Trephining. 6/4/58, Ventriculogram; cerebellar tumor removed. | | INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 23 , 19 58 , to June 6 , 19 58 , and that death occurred at 3:13 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Joseph M. Miller | | ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 6/6/58 | |
| PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service VAH, FT. HOWARD, MARYLAND | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 6-9-1958 | 22c. NAME OF CEMETERY OR CREMATORY E.U.B. Church Cemetery | 22d. LOCATION (City, town, or county) (State) Greenmount, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton Funeral Home, Hampstead, Md. | | 24a. REC'D BY REGISTRAR JUN 11 '58 | |
| 24b. REGISTRAR'S SIGNATURE Alfred | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be filled out by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. The funeral director should be notified of the death as soon as possible. The funeral director should be notified of the death as soon as possible. The funeral director should be notified of the death as soon as possible.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6614

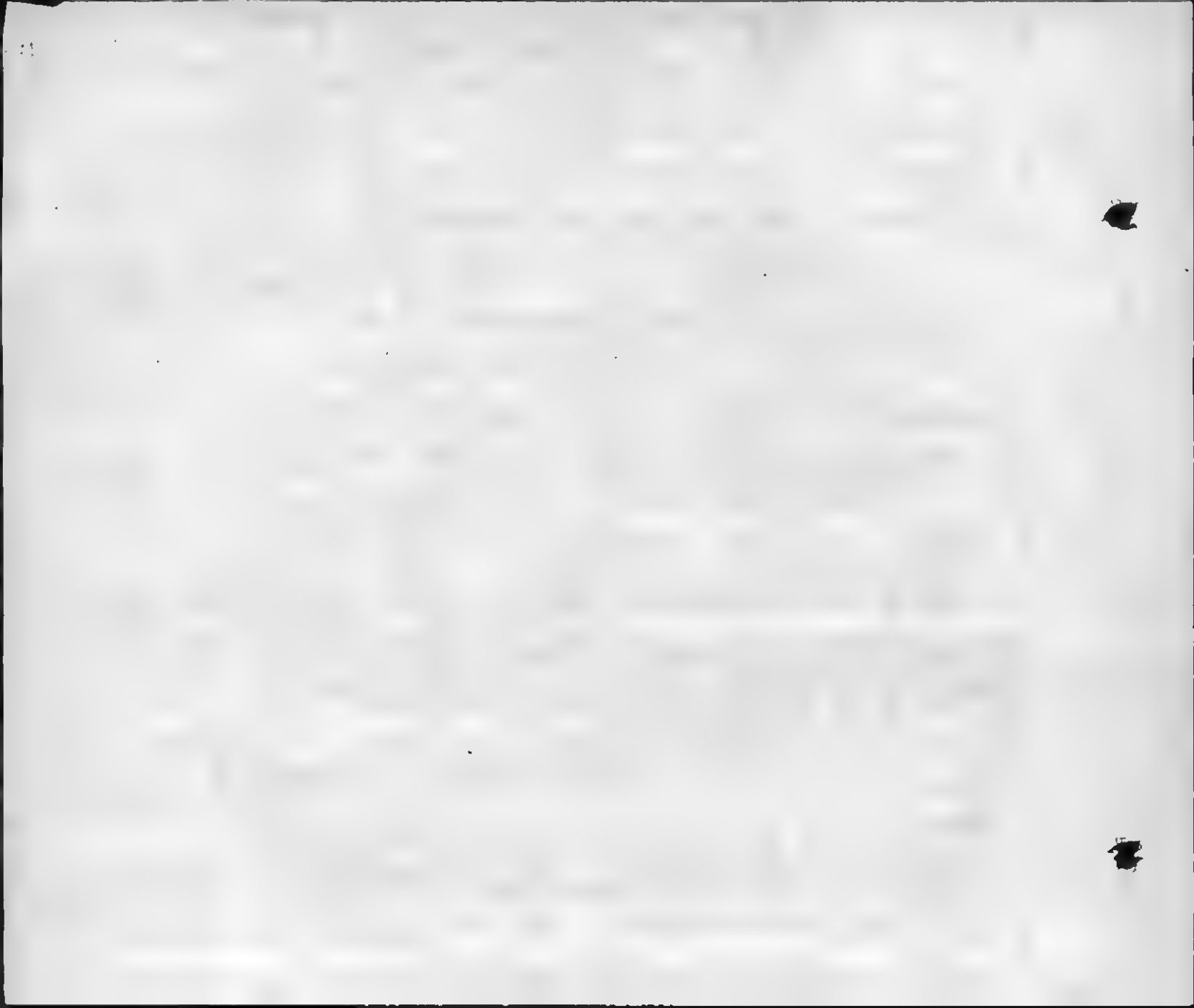
Item 8 Film 5231 7-14-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06603

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catanoville</u> | | | | c. LENGTH OF STAY IN 1b <u>Lifetime</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of the Pines</u> | | | | d. STREET ADDRESS <u>1241 Voght Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph W.</u> Middle <u>Scence</u> Last <u>Scence</u> | | | | 4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1958</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1902</u> <u>May 16-58</u> | |
| 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u> | | IF UNDER 24 HRS Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Cattle Industry</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>John Spence</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Turner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Peace time</u> | | 17. INFORMANT <u>Elaine Blackman</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Ca of Colon</u> DUE TO (b) <u>Ca of Left Lung</u> DUE TO (c) <u>Ca of Left Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>37 mo</u> <u>1 yr.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. n.</u> <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>5-16</u> , 1958, to <u>6-2</u> , 1958, that I last saw the deceased alive on <u>6-1</u> , 1958, and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wm. K. Gallagher</u> | | | | ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> | | DATE SIGNED <u>6-3-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Wm. K. Gallagher</u> | | | | <u>Baltimore-28, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>June 4-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Western</u> | | 22d. LOCATION (City, town, or county) (State) <u>Edmondson Ave.</u> <u>Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bone</u> | | | | ADDRESS <u>5646 Carville Ave.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 6 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Alfred</u> | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06604

6615

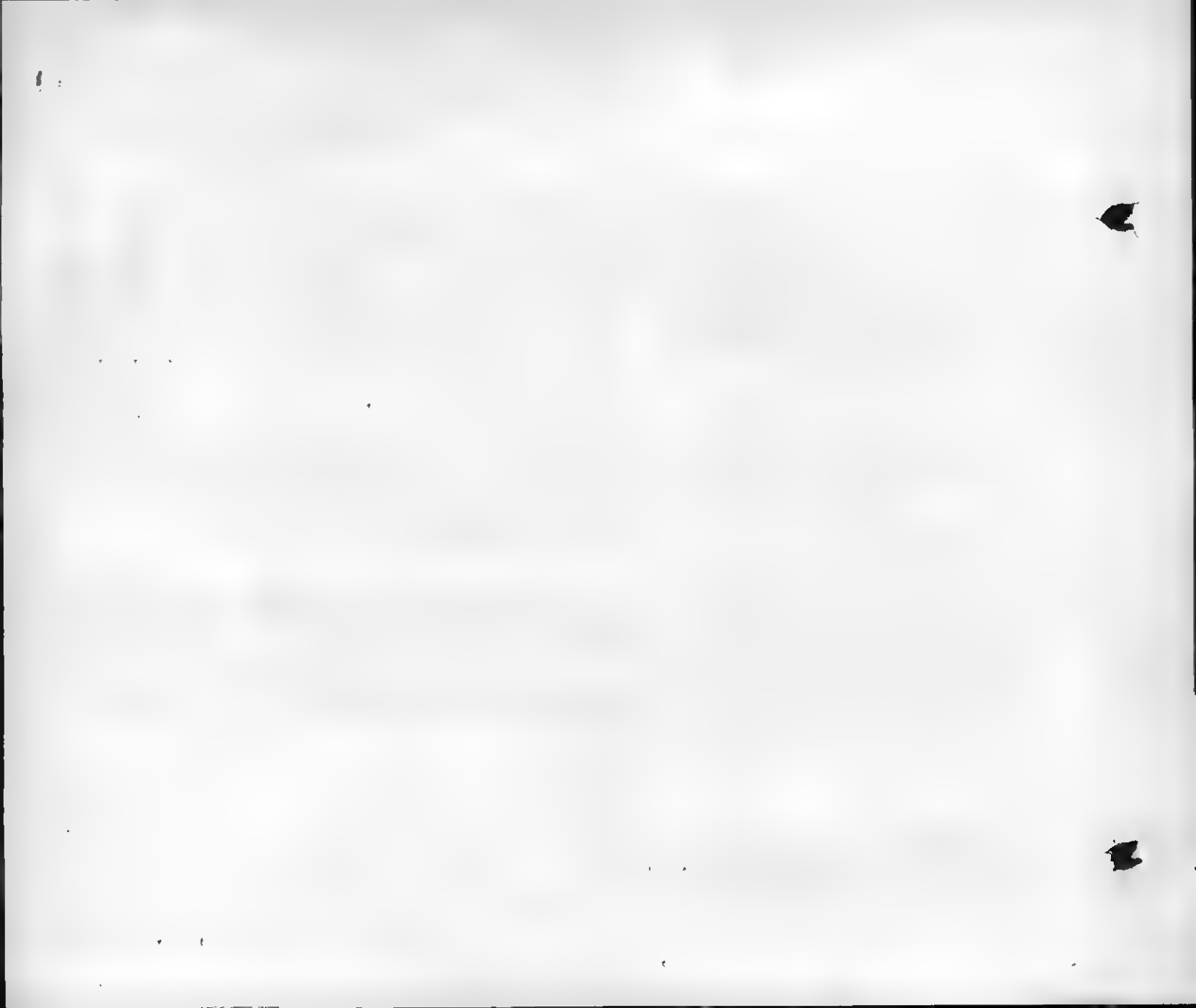
CERTIFICATE OF DEATH

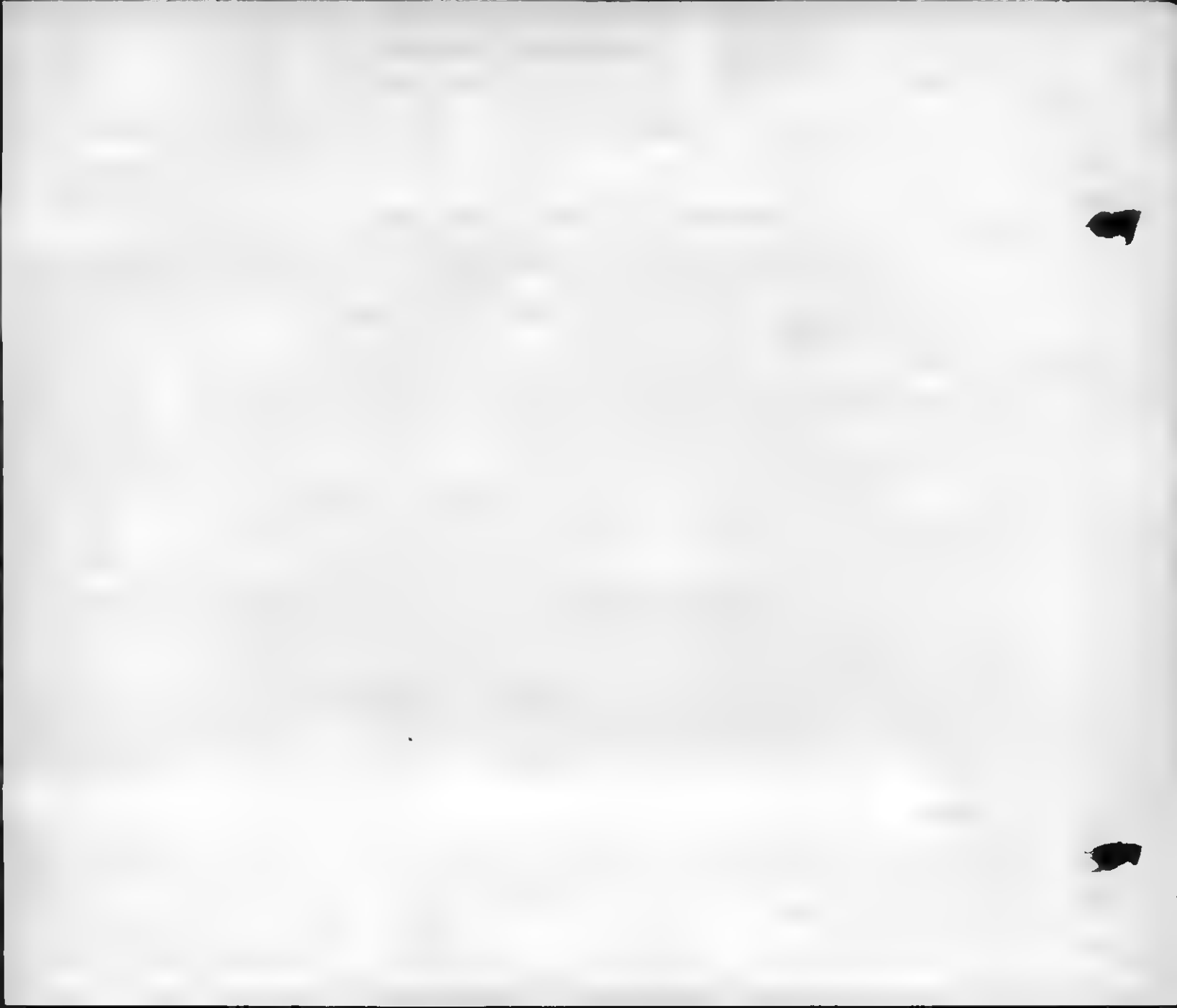
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 1mth19days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Langdon Last Spencer | | 4. DATE OF DEATH Month June Day 26 Year 19 58 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 12, 1867 |
| 9. AGE (In years last birthday) 91 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Massachusetts | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Marshall Langdon | | 14. MOTHER'S MAIDEN NAME Eleanor B. Brodie | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease | | | |
| 422.1 DUE TO Generalized arteriosclerosis | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 14 , 19 58 , to June 26 , 19 58 , that I last saw the deceased alive on June 26 , 19 58 , and that death occurred at 3:30a M, from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE Bruno Radauskas | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-26-58 | |
| PHYSICIAN'S NAME (Type) Bruno Radauskas, M. D. | | Catonsville 28, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF June 27/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Louden Park Crematory | | 22d. LOCATION (City, town, or county) (State) Baltimore 29 Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors | | ADDRESS 4101 Edmondson | |
| 24a. REC'D BY REGISTRAR 30 '58 | | 24b. REGISTRAR'S SIGNATURE Witzke | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





15
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06606

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a COUNTY <u>BALTIMORE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>MD</u> b COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Hereford</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>1607 ST PAUL ST</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Connie First P Middle Last SPRINKLE</u> | | 4 DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-28-1916</u> |
| 9. AGE (in years last birthday) <u>41</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION STATESVILLE NC</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>WALTER PARKS SPRINKLE</u> | | 14. MOTHER'S MAIDEN NAME <u>ELNICE AUSTIN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO <u>3-14-6254</u> | |
| 17. INFORMANT <u>Family Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>FRAC TURED SKULL, FRAC TURED NECK</u> | | | |
| 410.3 DUE TO (b) <u>FRAC TURED MANDIBLE</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Steel Framework of bridge collapsed & fell onto him.</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>Evening 6/23 1958</u> | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Gunpowder Falls</u> | 20f. (City or town) (County) (State) <u>Hereford BALTO. MD.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> | | M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>A. M. FRANCE</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>6/23/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | | 22b. DATE THEREOF <u>JUNE 24 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>John Burns Sons</u> | | 22d. LOCATION (City, town, or county) (State) <u>STATESVILLE NORTH CAROLINA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Sons</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 26 '58</u> | |
| ADDRESS <u>Towson & Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. French</u> | |

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Item 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

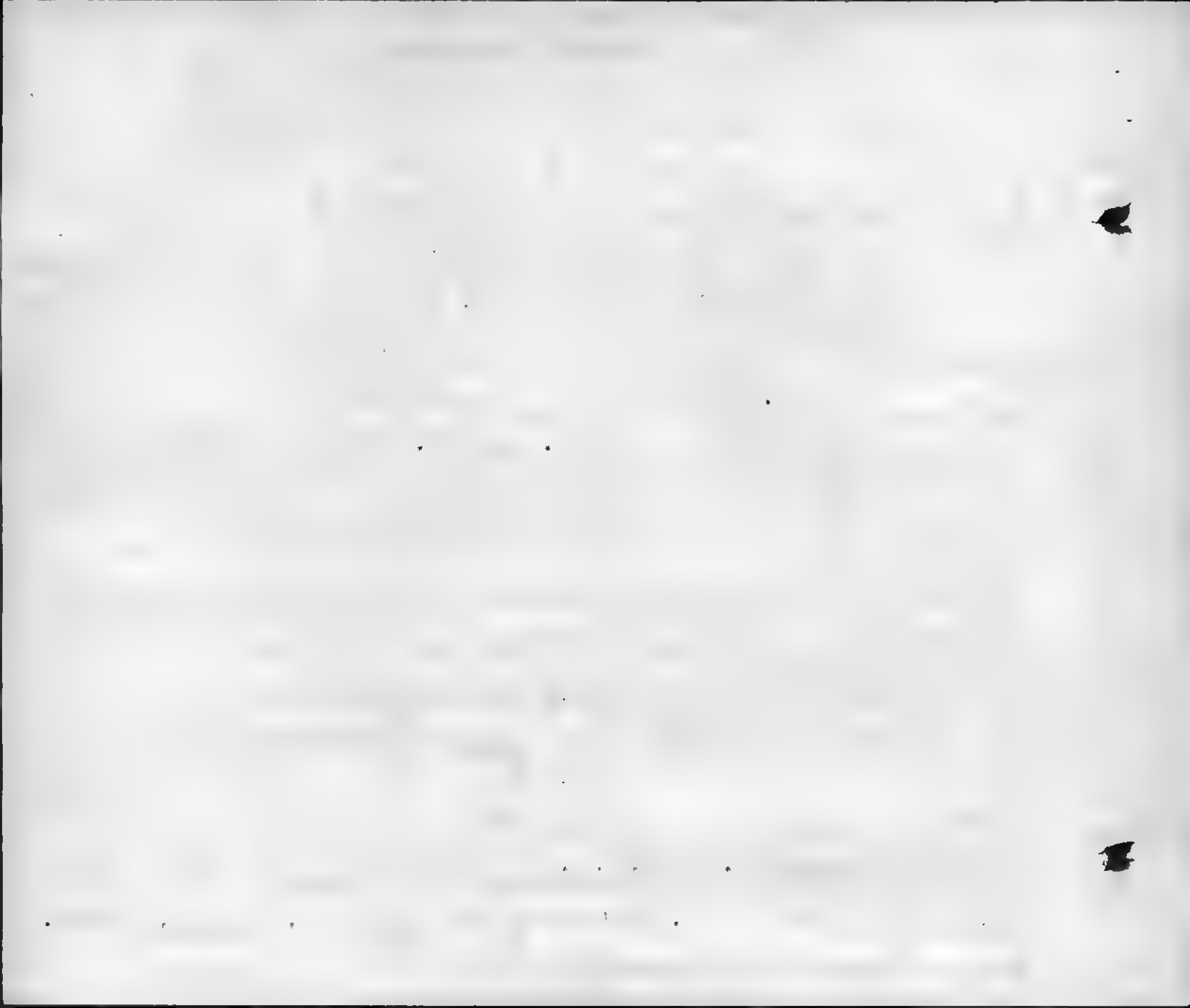
6618

CERTIFICATE OF DEATH

Reg. Dist. No.

06607

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 23 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Aigburth Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Daisy Middle Bordley Last Stafford | | | | 4. DATE OF DEATH Month June Day 21 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 13, 1868 | |
| 9. AGE (In years last birthday) 90 yrs. | | IF UNDER 1 YEAR Months 7 Days 21 Hours 12 Min. 00 | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | | | |
| 13. FATHER'S NAME William C. Bordley | | | | 14. MOTHER'S MAIDEN NAME Amelia Heritage | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 19 yes, give year or dates of service | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Mrs. Chester H. Collison | | | | Address 16 Aigburth Rd Towson 4 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Apoplexy DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 7 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from July 1948 to 21 June 1958 , that I last saw the deceased alive on 20 June 1958 , and that death occurred at 2 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Charles H. Reier M.D. | | | | ADDRESS (Street, city or town, state) 6701 York Rd Baltimore 12 Md | | | |
| PHYSICIAN'S NAME (Type) Charles H. Reier, M. D. | | | | DATE SIGNED 21 June 58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 6/23/58 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY St. John's Church Cemetery | | | | 22d. LOCATION (City, town, or county) (State) Waverly, Baltimore, Maryland. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. W. Weems & Son | | | | ADDRESS 805 N. Calvert St. | | | |
| 24a. REC'D BY REGISTRAR JUN 23 '58 | | | | 24b. REGISTRAR'S SIGNATURE | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6619

CERTIFICATE OF DEATH

Reg. Dist. No. **06608**

| | | | | | | | |
|--|-------------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE FLORIDA b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. LENGTH OF STAY IN TB 4 1/2 YEARS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SARASOTA. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME | | | | d. STREET ADDRESS 324 JULIA ST | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARTHA EVELYN STALEY | | | | 4. DATE OF DEATH Month JUNE Day 2 Year 1958 | | | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-6-1883 | | 9. AGE (In years last birthday) 75 yrs | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRactical NURSE | | 10b. KIND OF BUSINESS OR INDUSTRY 579-12-2528 | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U-S | |
| 13. FATHER'S NAME CHARLES O IMBREY | | | | 14. MOTHER'S MAIDEN NAME MAMANTHA CORBART | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO 579-12-2528 | | 17. INFORMANT Address Frank L Smith Jr. Cockeysville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199. DUE TO ADENO-CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Yrs. | |
| PART II.—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1-18 , 19 54 , to 5-30 , 19 58 , that I last saw the deceased alive on 5-30 , 19 58 , and that death occurred at 7:10 A.M. , from the causes and on the date stated above. Walter H. Cook ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED 6/2/58 | | | | | | | |
| ACTUAL SIGNATURE Walter H. Cook | | | | DATE SIGNED 6/2/58 | | | |
| INTENDING NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 22b. DATE THEREOF 6-3-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mana Sota Burial Park | | 22d. LOCATION (City, town, or county) (State) Florida | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR JUN 4 '58 | | 24b. REGISTRAR'S SIGNATURE C. J. ... | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6473

CERTIFICATE OF DEATH

Reg. Dist. No.

00609

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) 230 CLEVELAND STREET | | d. STREET ADDRESS 230 CLEVELAND AVE | |
| 3. NAME OF DECEASED (Type or print) First Middle Last PAUL T. STANKUS | | 4. DATE OF DEATH Month Day Year JUNE 23 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 5, 1890 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAIL OPERATOR BETH STEEL CO | | 10b. KIND OF BUSINESS OR INDUSTRY LITHUANIA | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN STANKUS | | 14. MOTHER'S MAIDEN NAME ELIZABETH | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-07-0839A | |
| 17. INFORMANT ONYA STANKUS | | Address 230 CLEVELAND ST. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) hypertensive arterioscleortic cardiovascular disease DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH one hr. years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/22/58 , 19____, to 6/23/58 , 19____, that I last saw the deceased alive on 6/22/58 , 19____, and that death occurred at 7:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. E. Baermann, M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED 33 Dundalk Ave. Dundalk 22, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | 6-27-58 | St. Alphonsus Cemetery, Belair Rd Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Ackerman | | 24. REC'D BY REGISTRAR June 27 '58 | |
| ADDRESS 637 Washington St | | 24b. REGISTRAR'S SIGNATURE Overman | |



276 34

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6620

CERTIFICATE OF DEATH

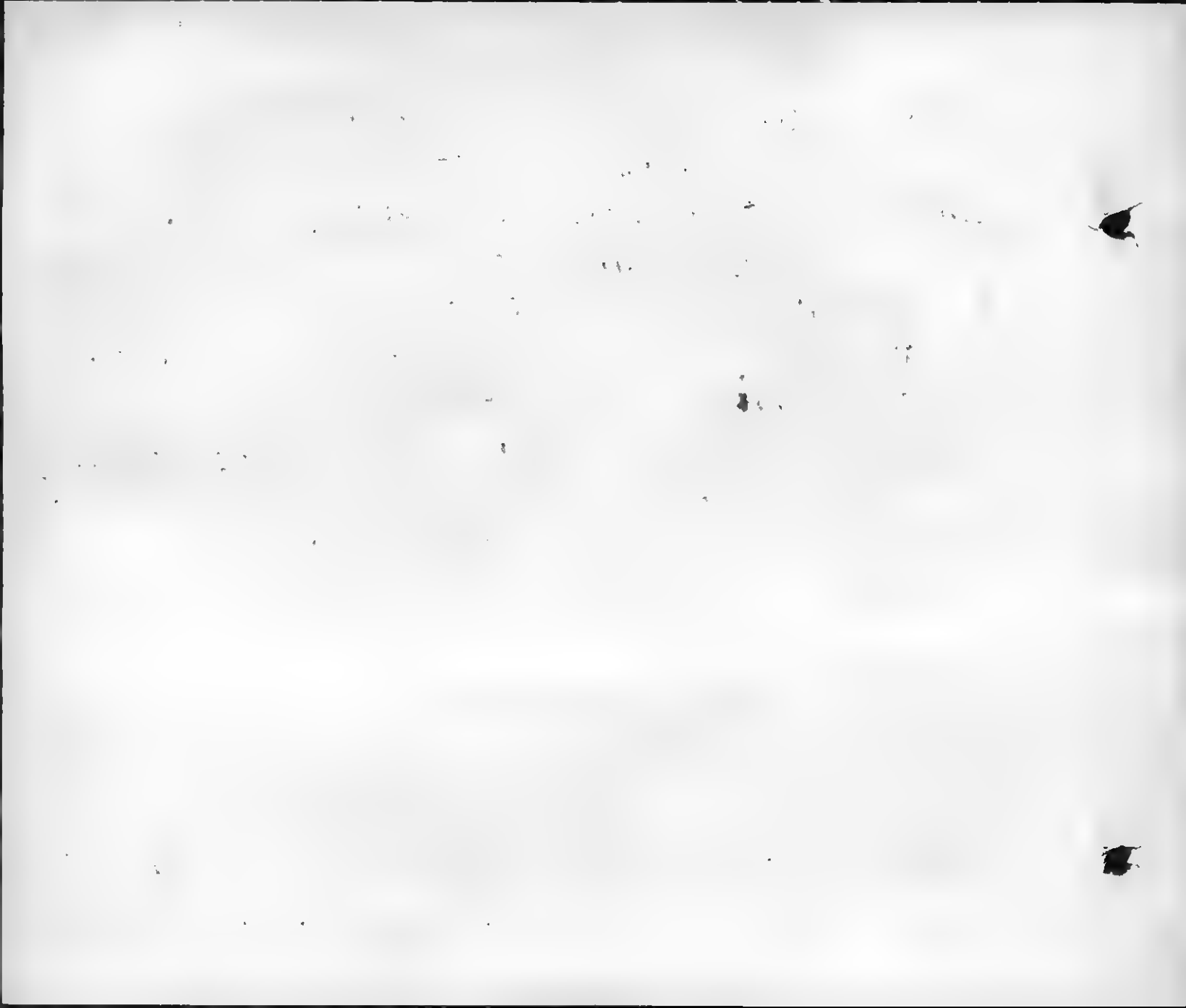
06610

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>Catonsville</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Spring Grove State Hospital</u> | | d. STREET ADDRESS <u>2211 W. Rogers Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Twiss</u> Last <u>Stevens</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-26-78</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Dexter Twiss</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Truesdale</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>Unknown</u> | |
| 17. INFORMANT <u>Pauline Jarboe</u> | | Address <u>2211 W. Rogers Ave. Baltimore, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Several years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>May 29, 1958</u> , to <u>June 21, 1958</u> , that I last saw the deceased alive on <u>June 21, 1958</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D. | | ADDRESS (Street city or town, state) <u>Spring Grove State Hospital</u> DATE SIGNED <u>6/21/58</u> | |
| PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u> | | <u>Catonsville 25, Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6/24/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Leckert</u> | | 24a. REC'D BY REGISTRAR <u>Wm J. Leckert</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Wm J. Leckert</u> | | DATE <u>JUN 24 '58</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6621

CERTIFICATE OF DEATH

06611

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|--|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Cuba b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havana | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 405 Dorsey Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Etta Faith Stewart | | | | 4. DATE OF DEATH Month Day Year June 9, 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 14, 1878. | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months Days 3 25 | IF UNDER 24 HRS Hours Min. 25 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister of Gospel | | 10b. KIND OF BUSINESS OR INDUSTRY Church Of God | | 11. BIRTHPLACE (State or foreign country) Iowa U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Joseph Stewart | | | | 14. MOTHER'S MAIDEN NAME Anna Stewart | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO None | | 17. INFORMANT Rev. Harold Barber Address 405 Dorsey Ave. Essex. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Standstill 9900 DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Bernicious anemia (c) undetermined | | | | | | INTERVAL BETWEEN ONSET AND DEATH 17 1/2 hrs Several weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/1 1958 to 6/9 1958 , that I last saw the deceased alive on 6/7 1958 , and that death occurred at 4 A.M. from the causes and on the date stated above | | | | | | | |
| ACTUAL SIGNATURE J. PLATT, M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED 434 EASTERN Ave. 6/10/58 Essex, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF JUNE 13-58 | | 22c. NAME OF CEMETERY OR CREMATORY SANTIAGO DE LOS VEGAS | | 22d. LOCATION (City, town, or county) (State) Havana, Cuba. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John S. Connelley Corp. Md. | | | | 24a. REC'D BY REGISTRAR DATE 6/12/58 | | 24b. REG. STRAR'S SIGNATURE A. W. Hedrick | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6622

CERTIFICATE OF DEATH

Reg. Dist. No. 06612

Item 8, Film G-231 7/7/58, cac.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. COUNTY <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleyville</u> | |
| c. LENGTH OF STAY IN 1b <u>10 yrs</u> | | d. STREET ADDRESS <u>1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>SARAH - T - STREVIK</u> | | 4. DATE OF DEATH <u>June 26 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 5 - 1895</u> |
| 9. AGE (In years last birthday) <u>73</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thornton Frank</u> | | 14. MOTHER'S MAIDEN NAME <u>Amanda Hare</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>R 15-01-7129</u> | |
| 17. INFORMANT <u>Russell Strevik</u> | | Address <u>Hampstead Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic heart disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>coronary atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 18</u> , 19 <u>58</u> to <u>June 26</u> , 19 <u>58</u> ; that I last saw the deceased alive on <u>June 23</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W H Foyard</u> M.D. | | ADDRESS (Street, city or town, state) <u>Manchester Md</u> | |
| DATE SIGNED <u>June 26 1958</u> | | PHYSICIAN'S NAME (Type) <u>W H Foyard</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6-28-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Grave Run</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u> | | ADDRESS <u>Hampstead Md</u> | |
| 24a. REC'D BY REGISTRAR <u>W. H. Foyard</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. H. Foyard</u> | |
| DATE <u>JUN 30 58</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records. For a burial, cremation, or removal, file pages 1 and 2 with the registrar for a burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

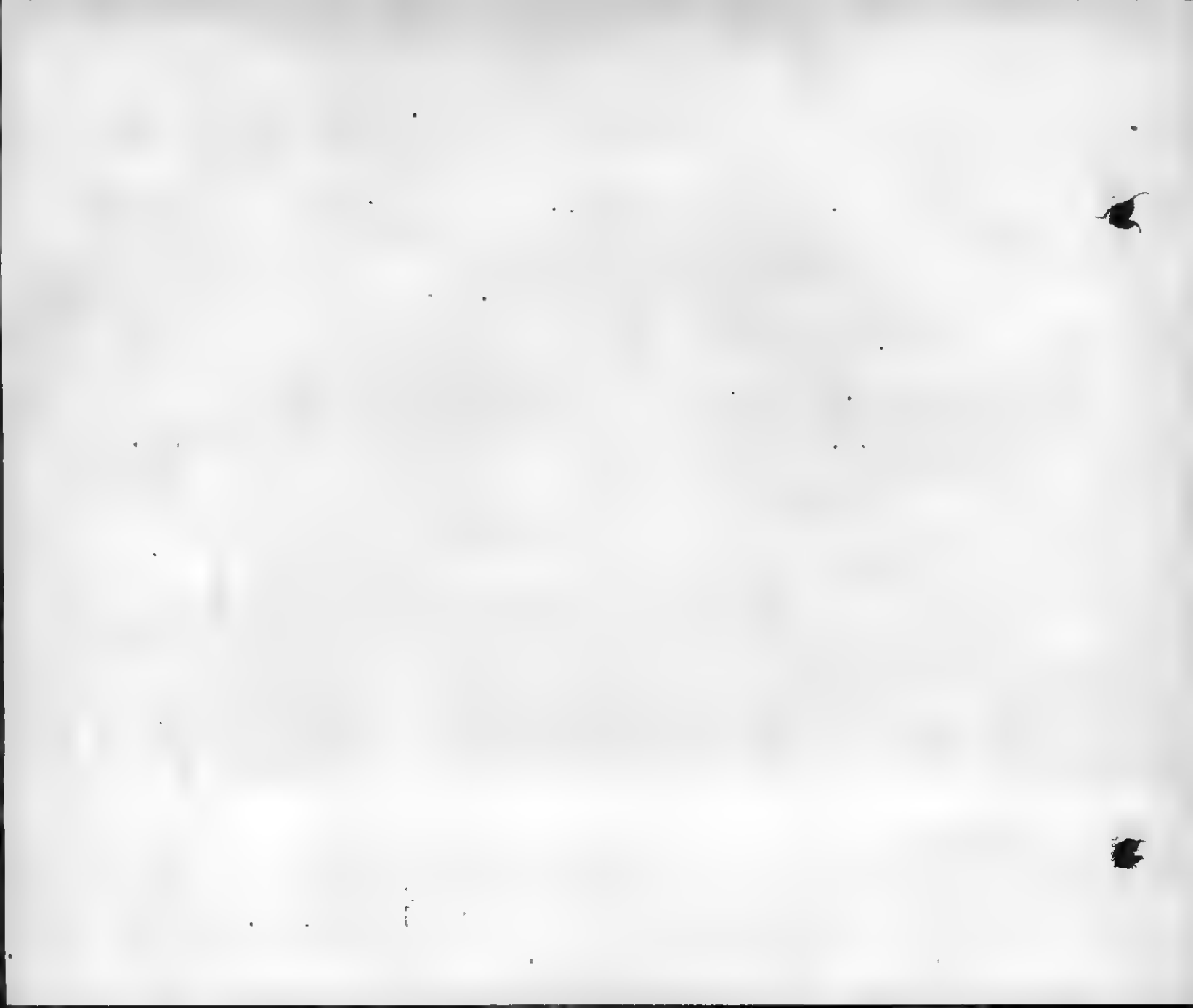
6623

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06613

| | | | | | | | |
|---|--|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Nicodemus Rd. near Gore's Mill Rd. | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg | | | |
| f. STREET ADDRESS Deer Park Road | | | | g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Emory Middle Franklin Last Stricker | | | | 4. DATE OF DEATH Month June Day 21 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 7, 1905 | 9. AGE (In years last birthday) 52 yrs. | IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min. | IF UNDER 24 HRS. Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Navy | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME James C. Stricker | | | | 14. MOTHER'S MAIDEN NAME Racheal R. Flater | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W.W.2 | | 17. INFORMANT Address J. Samuel Stricker, Finksburg, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull, hemorrhage DUE TO fall with car Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) auto accident DUE TO auto accident (c) auto accident | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 min |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2nd fall | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fractured skull, hemorrhage | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 6-21-58 Hour 4:15 P. M. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway | 20f. (City or town) Reisterstown | (County) Carroll | (State) Md. | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE L. L. Caples | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) D. D. CAPLES, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 24/58 | | 22c. NAME OF CEMETERY OR CREMATORY Providence | | 22d. LOCATION (City, town, or county) (State) Gamber, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons, Reisterstown, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 24 '58 | | 24b. REGISTRAR'S SIGNATURE W. E. Smith | |



6624

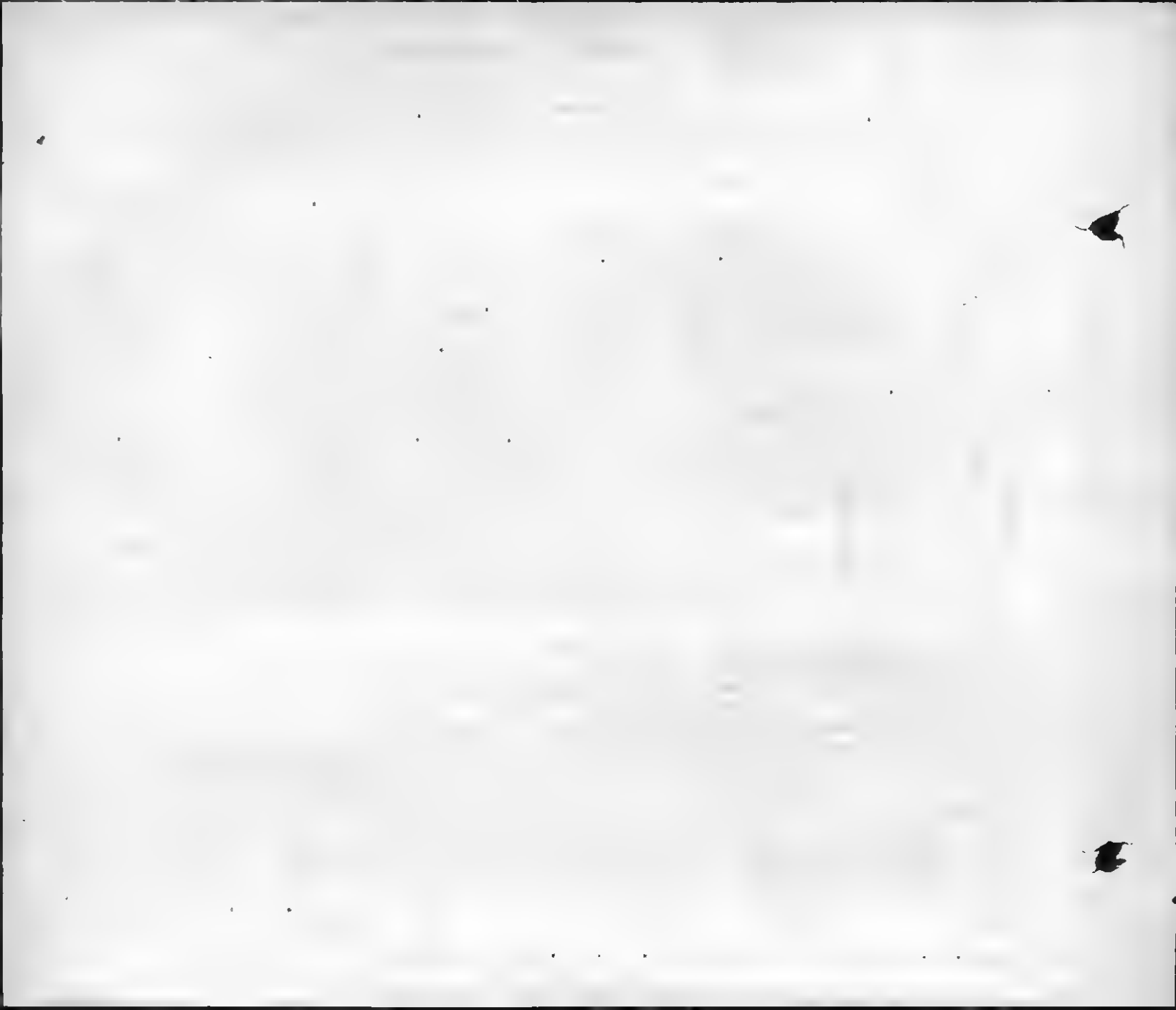
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph L. Tall</u> | | | | 4. DATE OF DEATH Month Day Year <u>June 23, 19 58</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 5, 1882</u> | 9. AGE (In years last birthday) <u>75</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper (rtd)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Landscapers</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Joseph L. Tall</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Cauzmall</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Address <u>Mrs. Anna E. Tall - 3312 Woodland Ave.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Vase Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old Left Paralysis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 19 57</u> to <u>June 19 58</u> that I last saw the deceased alive on <u>June 22, 19 58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4509 Liberty Key Rd an</u> DATE SIGNED <u>6-23-58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Dr. Thos G Abbott</u> M.D. | | | | PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/25/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. J. TICKNER & SONS - Balto. 17, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>JUN 24 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06615

6625

Reg. Dist. No.

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RUIDA-HERR FORD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>FREDERICK</u> Middle <u>TAYLOR</u> Last | | 4. DATE OF DEATH <u>JUNE</u> Month <u>5</u> Day <u>1958</u> Year | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 9, 1890</u> 67 yrs |
| 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Concocting Hydraulic Plant, Birmingham, England, USA</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY | |
| 13. FATHER'S NAME <u>Alfred F. Taylor</u> | | 14. MOTHER'S MAIDEN NAME <u>Alice M. Moorehouse</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>164-10-6407</u> | |
| 17. INFORMANT <u>Mrs. Richard F. Taylor</u> | | Address <u>Corbett & Madison Road, Norristown, MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>A. M. FRANCE</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>6/5/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u> | | 22b. DATE THEREOF <u>JUN 7 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Worthington</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> | | 24. REC'D BY REGISTRAR <u>June 10 '58</u> | |
| 25. REGISTRAR'S SIGNATURE <u>W. L. French</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

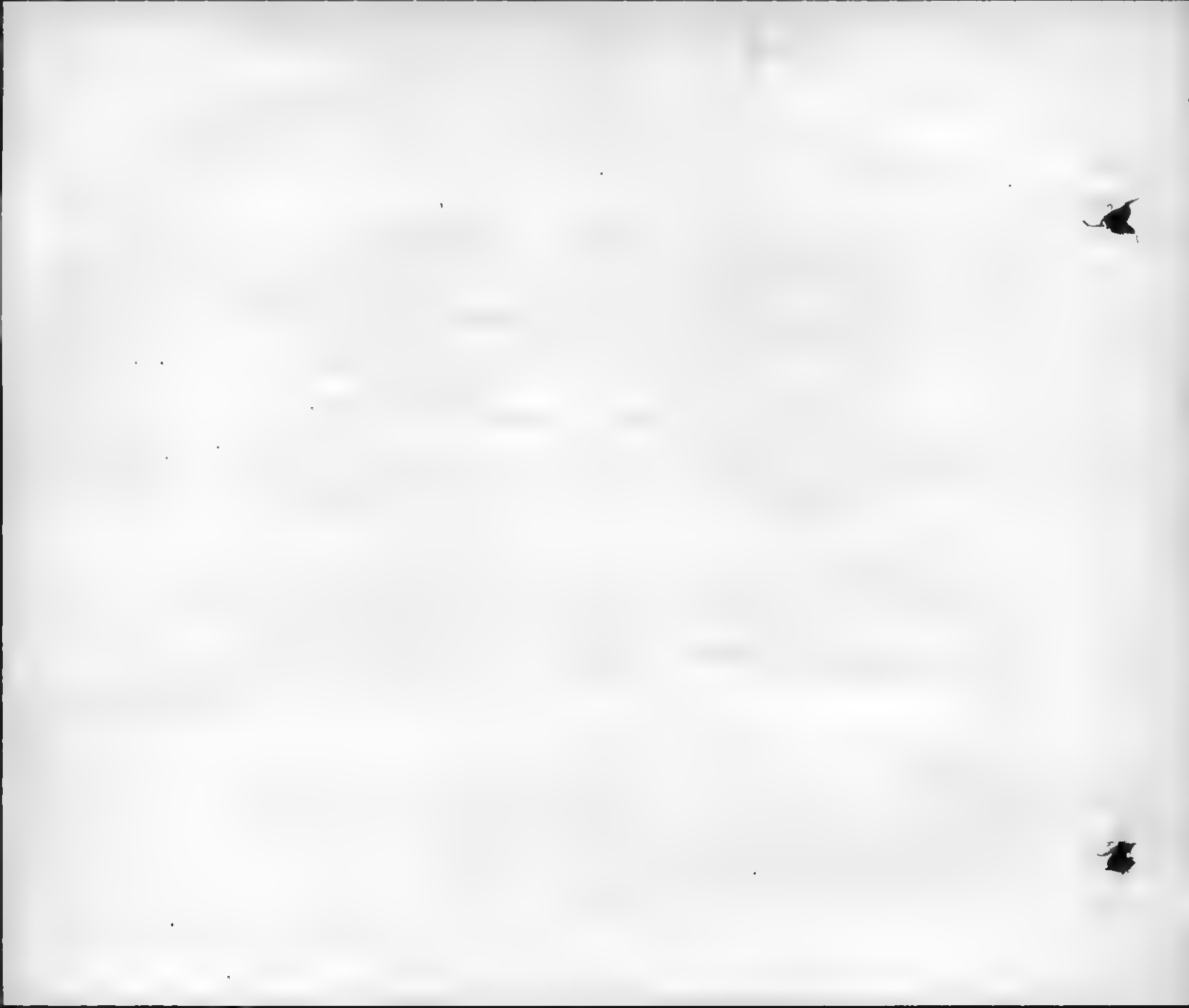
6626

CERTIFICATE OF DEATH

Reg. Dist. No.

06616

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution or Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn Catonsville | | c. LENGTH OF STAY IN 1b 10 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home | | d. STREET ADDRESS Rices's Lane | |
| 3. NAME OF DECEASED (Type or print) Helen Maria Thomas | | 4. DATE OF DEATH June 19 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 4, 1866 |
| 9. AGE (In years last birthday) 92 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 15 Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Principal retired | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, County, Md. | |
| 11. BIRTHPLACE (State or foreign country) U.S. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Elias Thomas | | 14. MOTHER'S MAIDEN NAME Catherine Louise MacKnew | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Frank L. Thomas, 3200 Offutt Rd. Randallstown | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal aortic aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 1958 to 1958, that I last saw the deceased alive on 6-19-58, 1958, and that death occurred at 3-PM, from the causes and on the date stated above | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE John A. Heston M.D. | | PHYSICIAN'S NAME (Type) John A. Heston, M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-23-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery | | 22d. LOCATION (City, town, or county) (State) Woodlawn Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE E. E. Smith | | ADDRESS 600 Liberty Heights Ave. | |
| 24a. REC'D BY REGISTRAR JUN 23 '58 | | 24b. REGISTRAR'S SIGNATURE A. E. Smith | |



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6627 CERTIFICATE OF DEATH

06617

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH Rosewood State Training School | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| a. COUNTY Baltimore | | MARYLAND | | o. STATE Maryland | | b. COUNTY City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland | | c. LENGTH OF STAY IN 1b 30 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17, Maryland | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | | | d. STREET ADDRESS 722 North Monroe Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ira Middle Thompson Last Thompson | | | | 4. DATE OF DEATH Month 6 Day 11 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/ /36 | 9. AGE (In years last birthday) 21 yrs | IF UNDER 1 YEAR Months 11 Days 11 Hours 19 Min 58 | IF UNDER 24 HRS Months 11 Days 11 Hours 19 Min 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? IRA G. THOMPSON | | | | 14. MOTHER'S MAIDEN NAME ? EMELIA CLARK | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT Rosewood Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia | | | | | | | |
| DUE TO (b) Nephrosis, lower nephron | | | | | | | |
| DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral palsy & mental deficiency | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5/13/58 , 19 58 , to 6/11/58 , 19 58 , that I last saw the deceased alive on 6/11/58 , 19 58 , and that death occurred at 3:05 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Rich. Liekeberg (P.K.) | | | | ADDRESS (Street, city or town, state) 700 Fleet Street Baltimore | | DATE SIGNED 6/14/58 | |
| PHYSICIAN'S NAME (Type) Rich. Liekeberg (P.K.) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-14-58 | | 22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Jackson Avenue Home | | ADDRESS 916 | | 24a. REC'D BY REGISTRAR DATE 6 JUN 3 1958 | | 24b. REGISTRAR'S SIGNATURE Overseer | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6628

CERTIFICATE OF DEATH

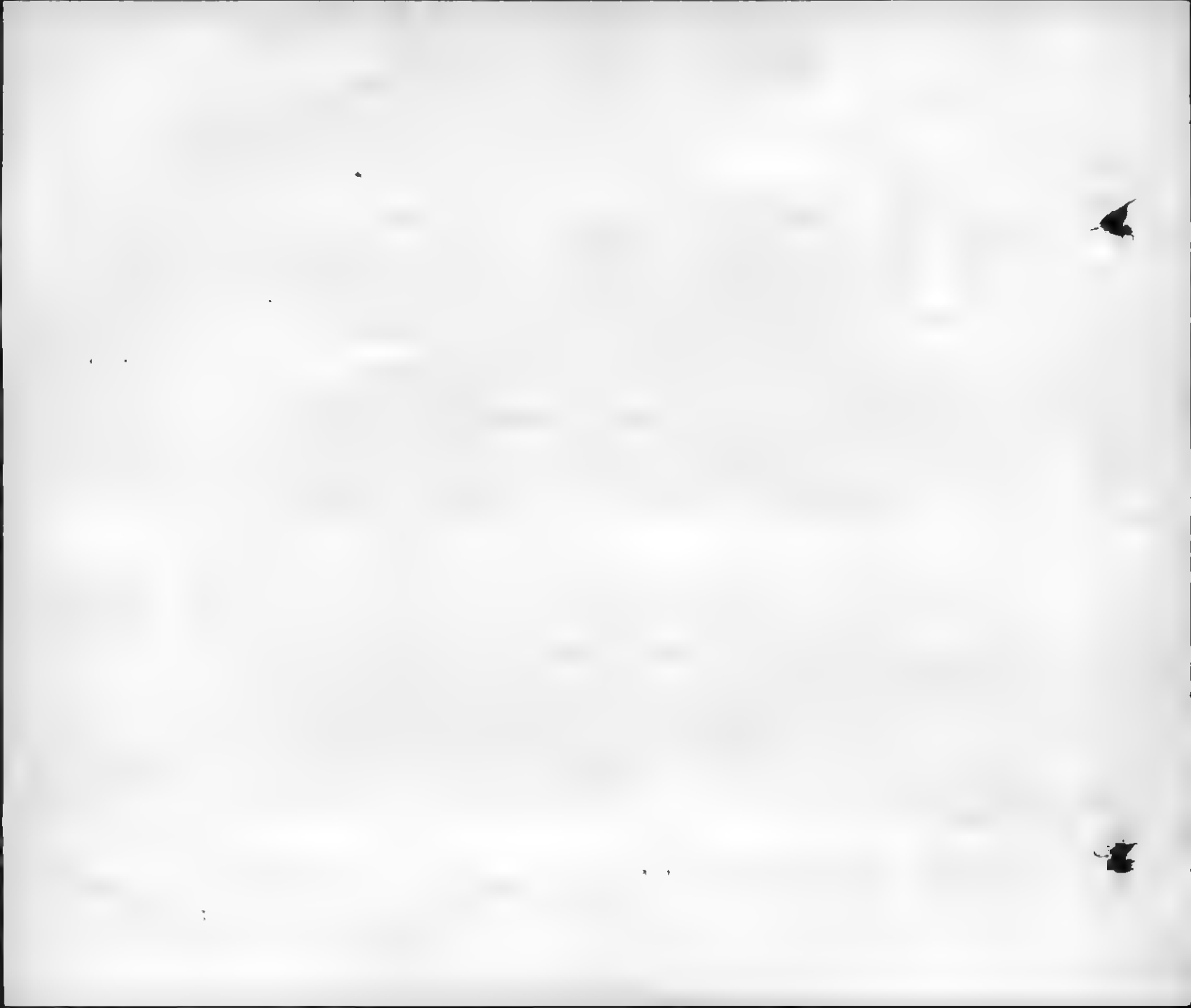
06618

Reg. Dist. No.

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | |
| c. LENGTH OF STAY IN 1b 28yr9mth4dys | | d. STREET ADDRESS no address | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Goff Last Tracy | | 4. DATE OF DEATH Month June Day 20 Year 19 58 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 16, 1902 |
| 9. AGE (In years last birthday) yrs 56 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handyman | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James Tracy | | 14. MOTHER'S MAIDEN NAME Mary MacDonald | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) unknown | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 10 , 19 58 , to 6/20 , 19 58 , that I last saw the deceased alive on 6/20/58 , 19 58 , and that death occurred at 5:30 P. M. from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE Stella Wachslor | | ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL | |
| PHYSICIAN'S NAME (Type) Stella Wachslor/ M.D. | | DATE SIGNED 6/20/58 | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal | | 22b. DATE THEREOF 6-26-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY W. & W. School | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | 24a. REC'D BY REGISTRAR | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |
| DATE JUN 1 1958 | | DATE JUN 1 1958 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6629

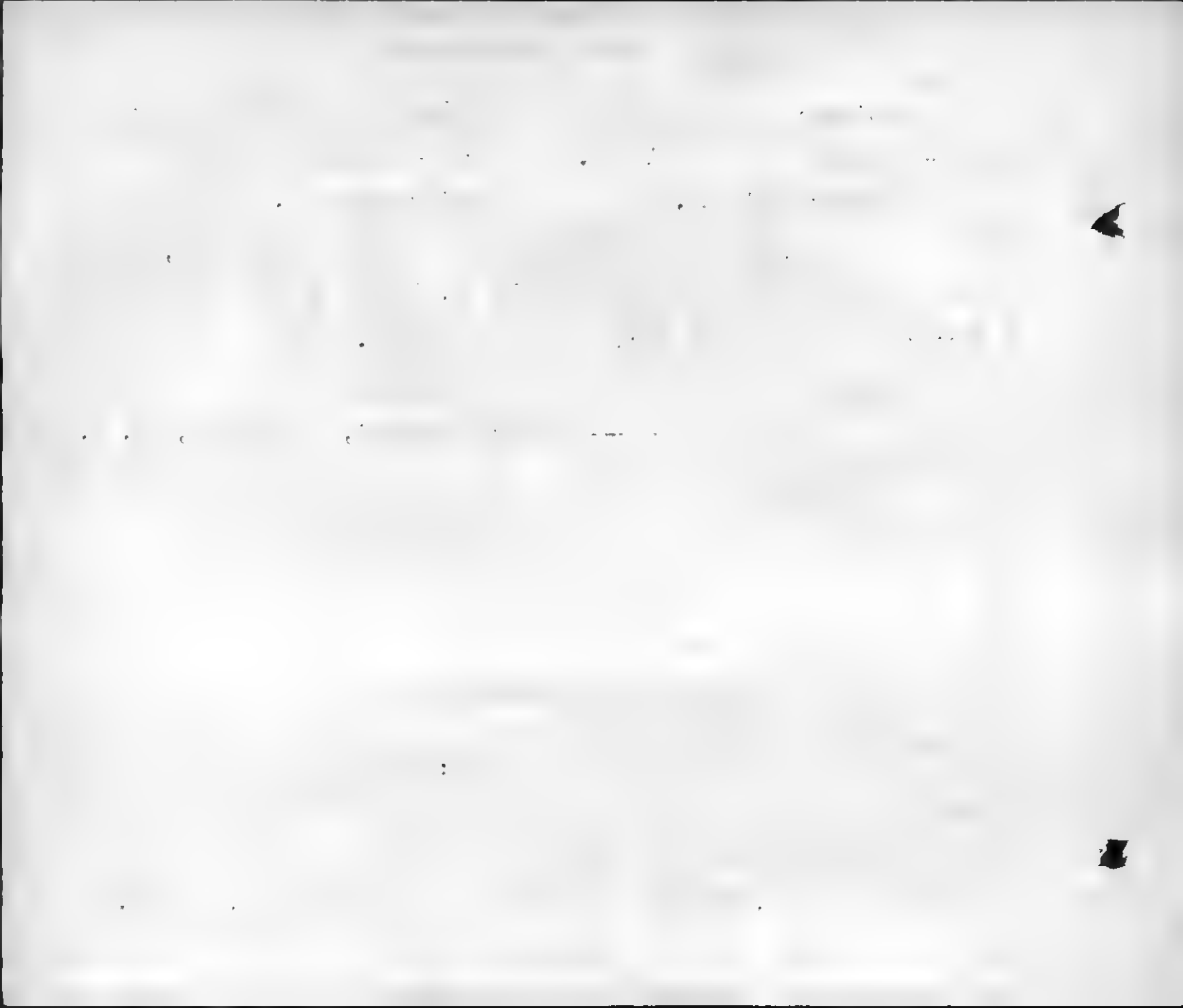
CERTIFICATE OF DEATH

Reg. Dist. No.

06619

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Parkton | | | | c. LENGTH OF STAY IN IB 41 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Stablersville Rd. | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JACOB Middle TUSZYNSKI Last | | | | 4. DATE OF DEATH Month June Day 28 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 12, 1874 | |
| 9. AGE (In years and birthday) 83 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | | IF UNDER 24 HRS Months Days Hours Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Farm | | 11. BIRTHPLACE (State or foreign country) Poland. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Peter Tuszynski, | | Address Parkton, Md. R. D. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arterio-Sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mos 10 yrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) White Hall, Md | | | | 20g. (County) White Hall, Md | | 20h. (State) Md | |
| 21. I certify that I attended the deceased from April 19, 1958 , to June 28, 1958 , that I last saw the deceased alive on June 28, 1958 , and that death occurred at 4:50 P. M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Milner Bortner M.D. | | | | DATE SIGNED 6/30/58 | | | |
| PHYSICIAN'S NAME (Type) Milner Bortner | | | | ADDRESS (Street, city or town, state) White Hall, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 2, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Jacob Kastenstem | | | | 24a. REC'D BY REGISTRAR DATE JUL 2 '58 | | 24b. REGISTRAR'S SIGNATURE W. Beach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

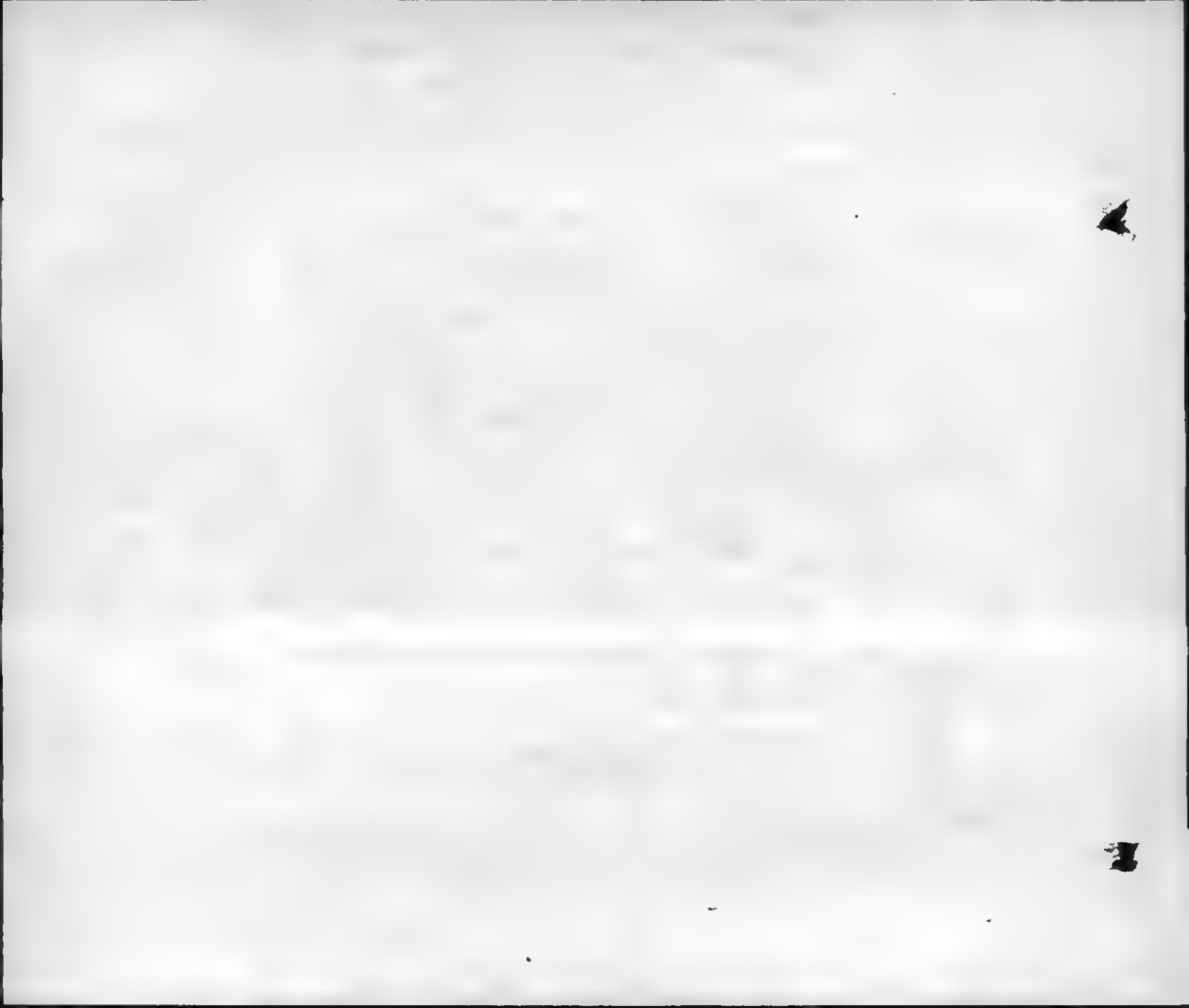
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6630

06620

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---------------------------------------|--|--|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> | | c. LENGTH OF STAY IN 1b <u>50 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>347 Upperlanding Rd.</u> | | | | d. STREET ADDRESS <u>347 Upperlanding Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF <u>MARIE</u> First Middle Last <u>WHL</u> | | | | 4. DATE OF DEATH <u>June 24 1958</u> | | | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 1 - 1877</u> | | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-keeper</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT-Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Charles Klutsch</u> | | | | 14. MOTHER'S MAIDEN NAME <u>?</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213-12-0832</u> | | 17. INFORMANT <u>Robert WHL - SAME</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>4x0.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart dis.</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>10 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>Jack C Collins</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>JACK C COLLINS</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 27-58</u> | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY <u>Schwartz Com.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly - Essex - Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>June 30 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u> | |



6474

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 DUNDALK 22 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7949 Saint Bridget Lane | | | | e. STREET ADDRESS 7949 Saint Bridget Lane | | | |
| | | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First George Middle Vechio Last Vechio | | | | 4. DATE OF DEATH Month June Day 23 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 1, 1867 | | 9. AGE (In years last birthday) 91 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevadore (ret'd) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME unknown | | | | 14. MOTHER'S MAIDEN NAME unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yet no or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Michael Vechio, 7949 Saint Bridget Lane | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Due to (c) Due to | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month 19 Hour 0 a. m. 0 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | (State) |
| 21. I certify that I attended the deceased from 6/23/58 to 6/25/58 that I last saw the deceased alive on 6/25/58 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2505 W. Woodlawn Rd. Baltimore, Md. DATE SIGNED 6/25/58 | | | | | | | |
| ACTUAL SIGNATURE Oswald B. Harris | | PHYSICIAN'S NAME (Type) Oswald B. Harris MD Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-25-58 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR DATE JUN 25 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur Smith | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6631

Item 5 Filed 6-12-58 et

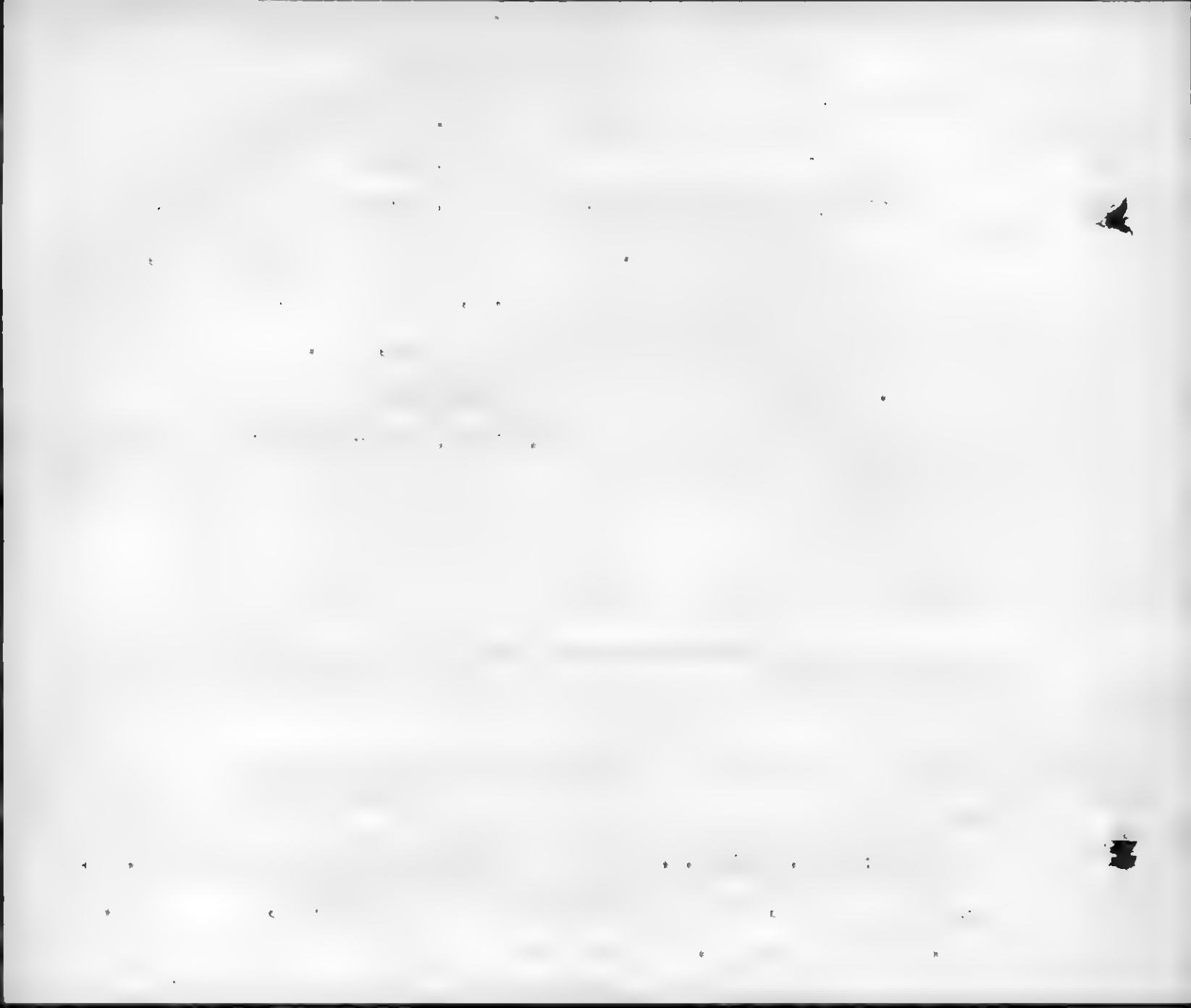
CERTIFICATE OF DEATH

06622

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lochearn | | c. LENGTH OF STAY IN 1b X Lochearn | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6218 Liberty Heights Terrace | | d. STREET ADDRESS 6218 Liberty Heights Terrace | |
| 3. NAME OF DECEASED (Type or print) First John Middle W. Last Wagner | | 4. DATE OF DEATH Month June Day 6 Year 1958 | |
| 5. SEX Male Female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 7, 1894 |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assessor | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore City | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY | |
| 13. FATHER'S NAME Louis P. Wagner | | 14. MOTHER'S MAIDEN NAME Emma Hoerr | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Lina B. Wagner | | Address 6218 Liberty Heights Terrace | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 2 mo |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Dec 1957 to June 1958 , that I last saw the deceased alive on 6 June 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2 June 1958 | | | |
| ACTUAL SIGNATURE Marvin H. Davis M.D. | | | |
| PHYSICIAN'S NAME (Type) Marvin H. Davis M.D. | | 6512 Liberty Road Baltimore Co. Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF June 11, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Zoar Baptist Church | 22d. LOCATION (City, town, or county) (State) Deltaville, Va. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Rutaw Place | | 24a. REC'D BY REGISTRAR JUN 9 '58 24b. REGISTRAR'S SIGNATURE Overton | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6632

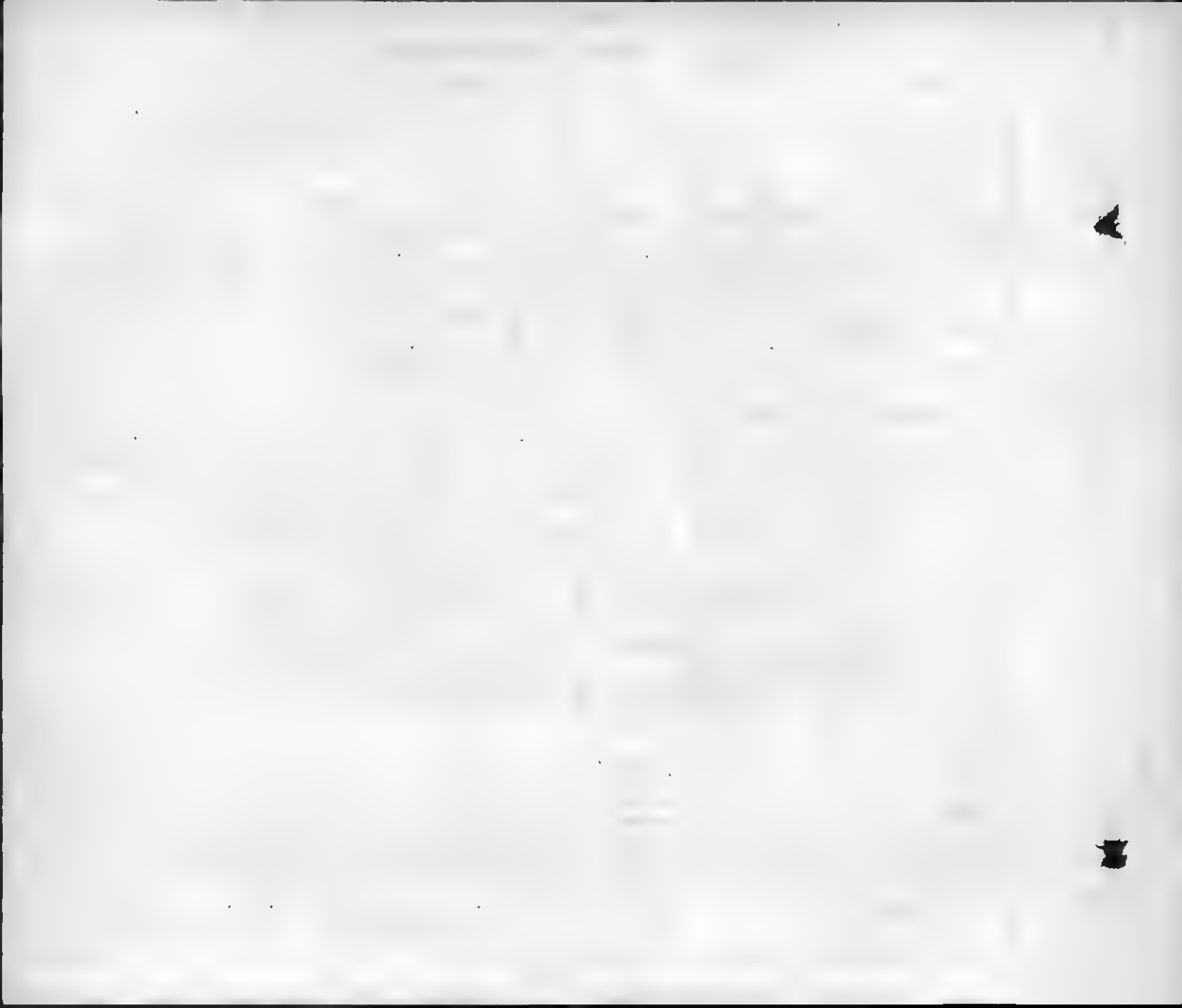
CERTIFICATE OF DEATH

Reg. Dist. No. **06623**

| | | | | | | | |
|--|------------------------------|--|--|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Balto. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 3 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5640 Willow Oak Rd. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Peter Middle J. Last Ward Sr. | | | | 4. DATE OF DEATH Month June Day 24 Year 1958 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 10, 1872 | | 9. AGE (In years last birthday) 85 yrs. | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hatmaker - Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY Self Emp. | | 11. BIRTHPLACE (State or foreign country) Penn. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Ward | | | | 14. MOTHER'S MAIDEN NAME Rose McGuire | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edw. J. Ward Address 8640 Willow Oak Rd. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arterio-sclerosis DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/15, 1958 , to 6/24, 1958 , that I last saw the deceased alive on 6/24, 1958 , and that death occurred at 2 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Gordon Brown | | | | DATE SIGNED 6/25/58 | | | |
| PHYSICIAN'S NAME (Type) GORDON GRAU MD | | | | 5513 Loch Raven Blvd Towson MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-27-58 | | 22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem. | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home | | | | ADDRESS Catonville, Md. | | 24a. REC'D BY REGISTRAR JUN 30 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. K. Smith | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

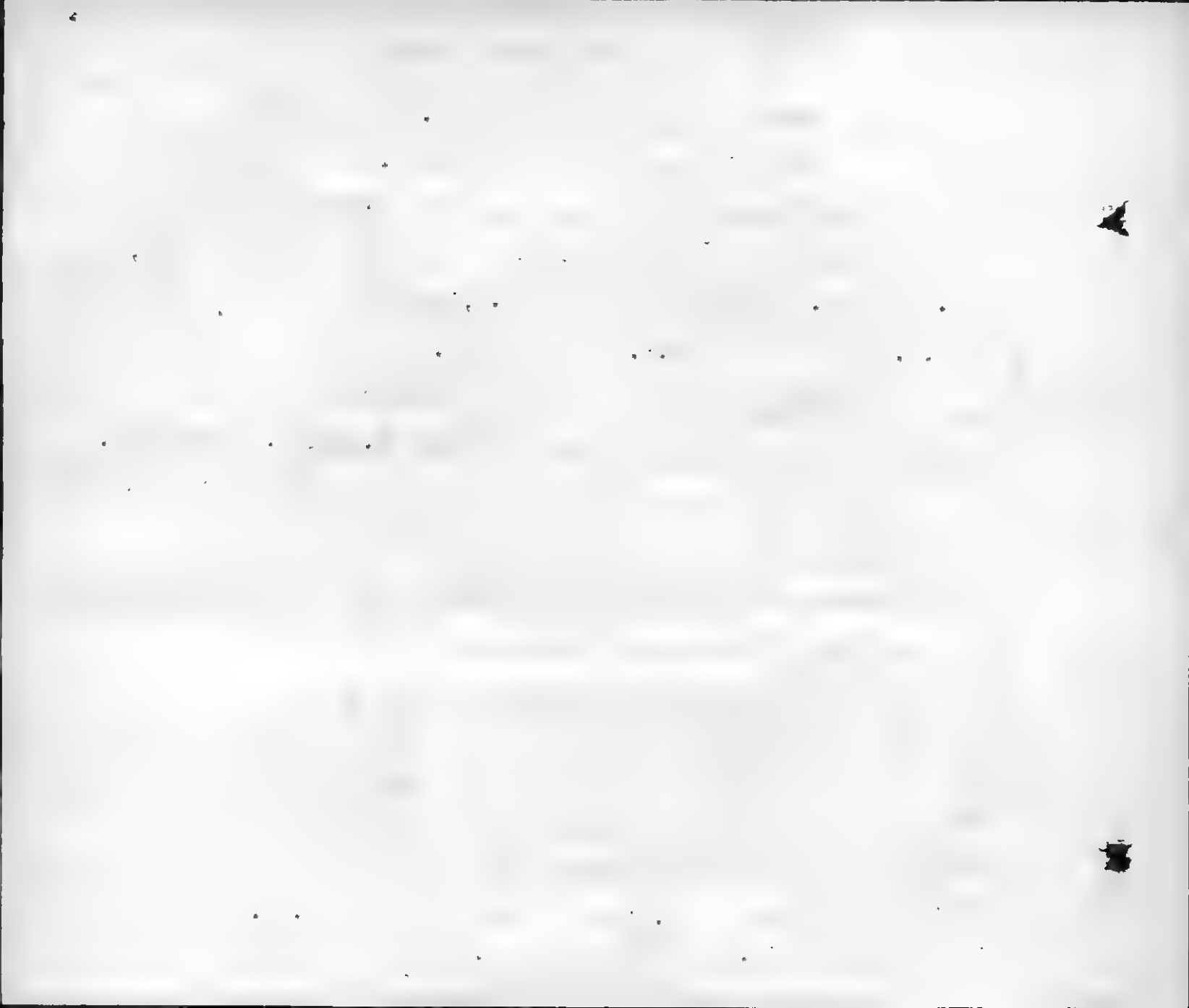
6633

CERTIFICATE OF DEATH

Reg. Dist. No.

06624

| | | | |
|--|----------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor | | d. STREET ADDRESS 3501 W. Franklin St | |
| 3. NAME OF DECEASED (Type or print) First CAROLINE Middle WATSON Last | | 4. DATE OF DEATH Month June Day 17 Year 19 58 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 4, 1870 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR: Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY O.H. | |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Hasz | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Edwin Watson Jr. | | Address 3501 W. Franklin St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3 - x DUE TO Cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Complicated by arteriosclerosis DUE TO Hypertension (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 1, 1958 to June 17, 1958 , that I last saw the deceased alive on June 16, 1958 , and that death occurred at 6:13 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE J. Wilson McKay, M.D. M.D. 6-14-58 | | ADDRESS (Street, city or town, state) 6-17-58 | |
| PHYSICIAN'S NAME (Type) J. Wilson McKay, M.D. | | DATE SIGNED 6-17-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/19/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. | | ADDRESS 4101 Edmondson Ave. | |
| 24a. REC'D BY REGISTRAR JUN 18 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. Beach | |



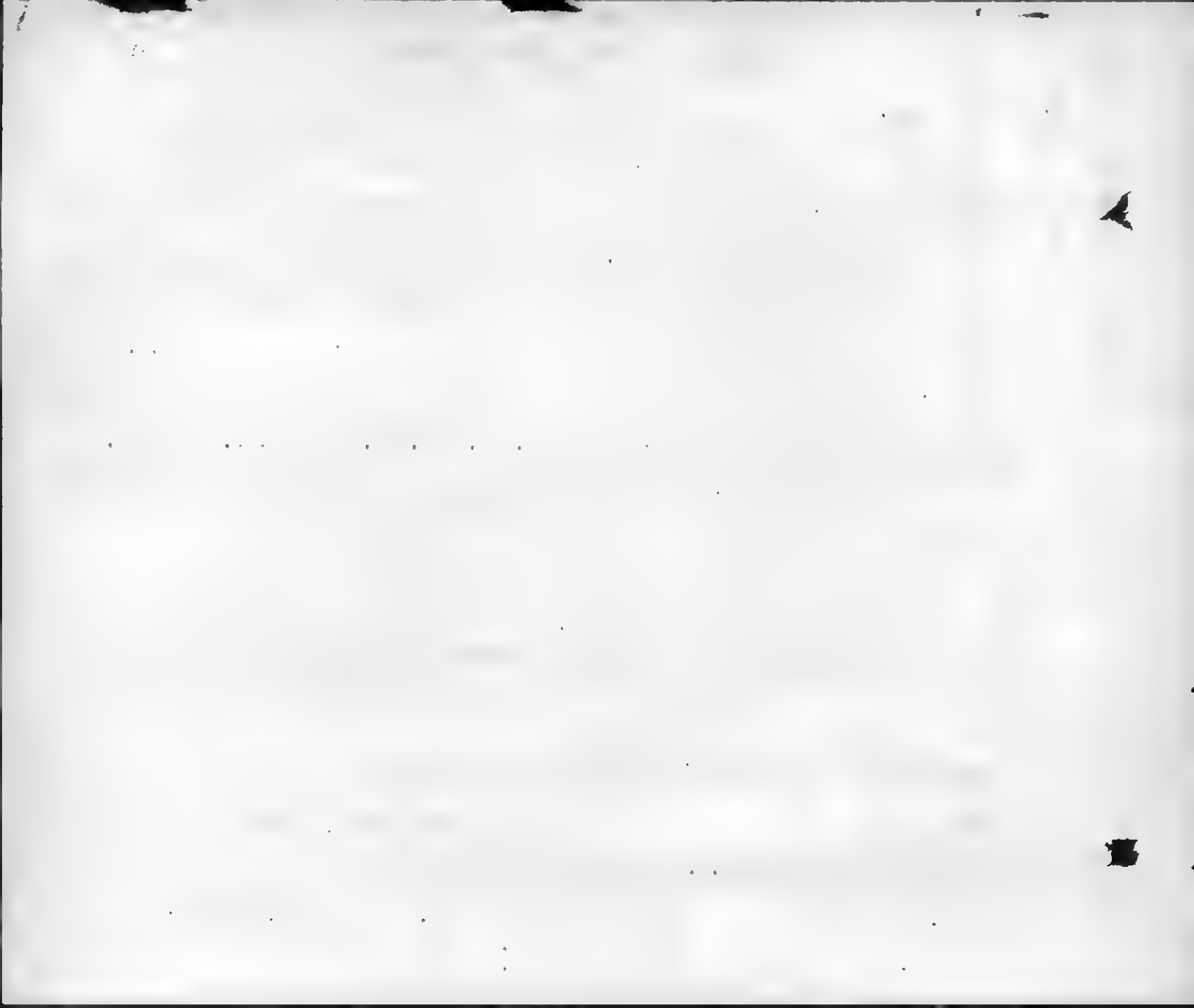
6634

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN lb 14 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V. 1. 4. | | | |
| f. STREET ADDRESS 2526 Garrett Avenue | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last EDWARD A. WELLS | | | | 4. DATE OF DEATH Month Day Year June 29 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 7, 1916 | |
| 9. AGE (In years last birthday) 42 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. 42 | | 11. IF UNDER 24 HRS. Months Days Hours Min. 42 | | 12. IF UNDER 24 HRS. Months Days Hours Min. 42 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | | | 10b. KIND OF BUSINESS OR INDUSTRY Apartment House | | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Lloyd Wells | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Johnson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. 219-01-5548 | | | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PARTIAL CORONARY OCCLUSION 420. DUE TO SEVERE CORONARY ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from June 15 , 19 58 , to June 29 , 19 58 , and that death occurred at 9:35 P.M. , from the causes and on the date stated above. CHEN WEI LAN, M.D. ADDRESS (Street, city or town, state) DATE SIGNED 6/30/58 | | | | | | | |
| ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND | | | | | | | |
| PHYSICIAN'S NAME (Type) CHEN WEI LAN, M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 7-3-58 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary | | | | 24a. REC'D BY REGISTRAR DATE JUL 2 '58 | | | |
| 24b. REGISTRAR'S SIGNATURE W. H. Seuch | | | | | | | |

TO ATTEND: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filled with the funeral director, and page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06626

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|-------------------------------|--|---|--|--|--|--|---------------|--|--|------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6825 Holabird Avenue | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 6825 Holabird Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle C. Last Wenig | | | | 4. DATE OF DEATH Month June Day 3 , Year 1958 | | | | | | | | | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 29, 1897 | | 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Foreman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Shipyard | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME George Wenig | | | | | | 14. MOTHER'S MAIDEN NAME Lena Homberg | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Nellie Wenig, 6825 Holabird Avenue | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction </td> <td rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH Immediately approx. 15 yr. </td> </tr> <tr> <td colspan="2"> 42001 DUE TO </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> </tr> <tr> <td colspan="2"> (b) Hypertensive Cardio Vascular Disease </td> <td></td> </tr> <tr> <td colspan="2"> DUE TO </td> <td></td> </tr> <tr> <td colspan="2"> (c) </td> <td></td> </tr> </table> | | | | | | | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH Immediately approx. 15 yr. | 42001 DUE TO | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Hypertensive Cardio Vascular Disease | | | DUE TO | | | (c) | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH Immediately approx. 15 yr. | | | | | | | | | | | | | | | | | | | | | |
| 42001 DUE TO | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Hypertensive Cardio Vascular Disease | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>W.E. Baermann</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) W.E. BAERMANN, M.D. | | | | DATE SIGNED 4 June 1958 | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF June 6, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State) Balto. Co., Md. | | | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home, Dundalk, Md. | | | | 24a. REC'D BY REGISTRAR DATE JUN 5 '58 | | 24b. REGISTRAR'S SIGNATURE <i>Alfred</i> | | | | | | | | | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

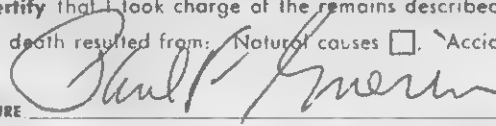
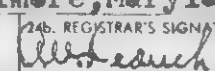
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6483

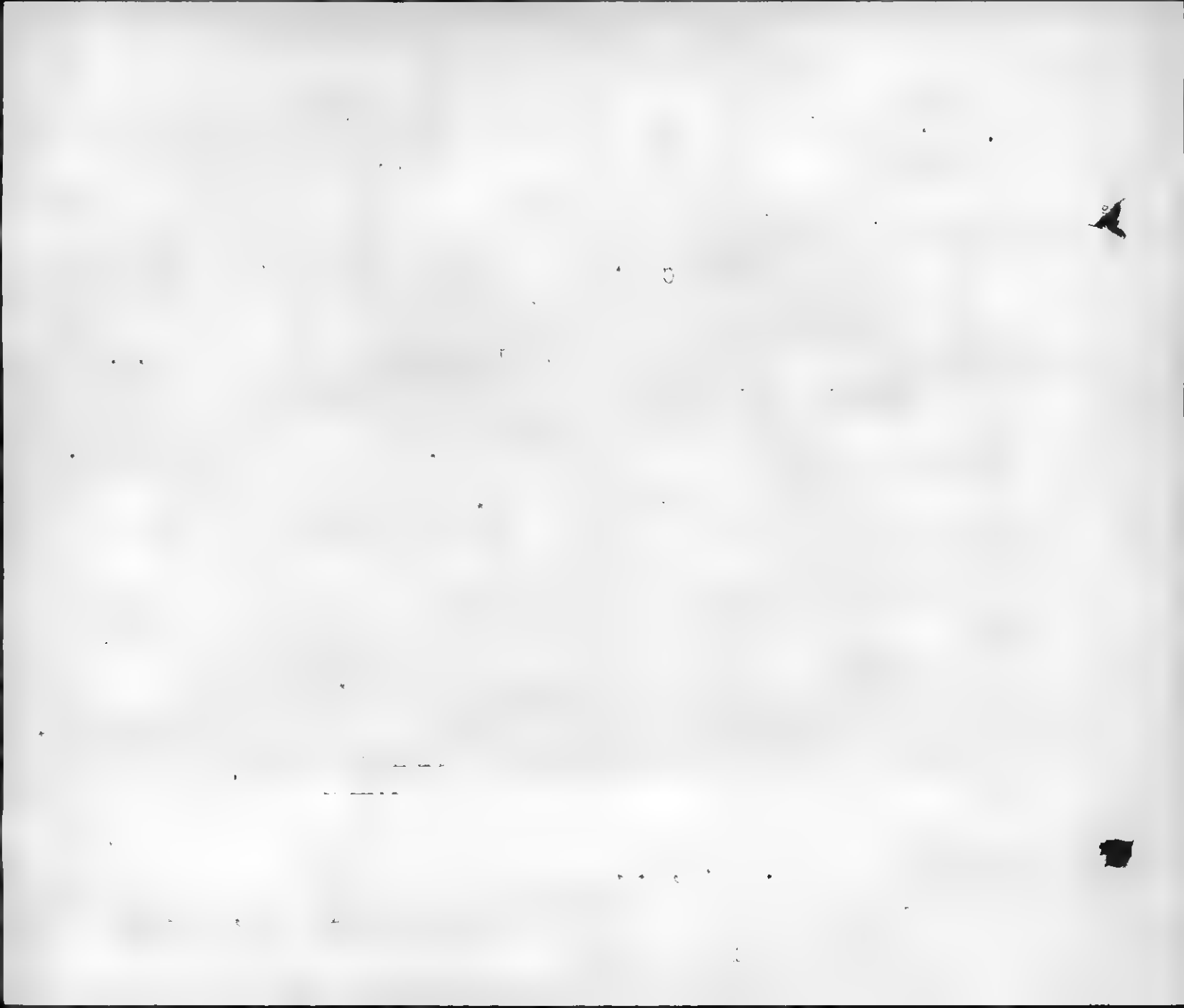
Reg. Dist. No.

06627

FOR STATE
HEALTH DEPT.

| | | | | | |
|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arbutus c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4415 Wilkens Avenue | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus d. STREET ADDRESS 4415 Wilkens Avenue | | e. IS RESIDENCE ON / FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last STEPHEN E. WHARTON | | 4. DATE OF DEATH Month Day Year June 21 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 7-24-1899 | | 9. AGE (in years last birthday) 58 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____ | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | |
| 11. BIRTHPLACE (State or foreign country) Crown Cork & Seal Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME Edward S. Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Edward S. Wharton 1003 Hallimont Rd. #28 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cranio-cerebral Injury. DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____ | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Beaten on head during altercation. | | 20c. TIME OF INJURY Month, Day, Year Hour 3:01 p.m. 6/21 1958 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Baltimore Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input type="checkbox"/>. Inquiry <input type="checkbox"/>. and in my opinion death resulted from: Natural causes <input type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input checked="" type="checkbox"/>. Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Paul F. Guerin, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 6/23/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-26-58 | | 22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue | | | |
| 24a. REC'D BY REGISTRAR JUN 25 '58 | | 24b. REGISTRAR'S SIGNATURE  | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6635

CERTIFICATE OF DEATH

Reg. Dist. No. 06628

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX 21 | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 511 N. Marlyn Avenue | | | | d. STREET ADDRESS 511 N. Marlyn Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Eva Middle G. Last Whitacre | | | | 4. DATE OF DEATH Month June Day 8 Year 1958 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH March 23, 1931 | |
| 9. AGE (In years last birthday) yrs. 27 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PLAINFIELD, N.J. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Thomas Corcoran | | | | 14. MOTHER'S MAIDEN NAME Alice Wolfe | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Robert J. Whitacre, 511 N. Marlyn Avenue | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Cerebral neoplasm vs. Asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 1951 to 6/8, 1958 , that I last saw the deceased alive on 6/6, 1958 , and that death occurred at 8 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 424 Eastern Ave DATE SIGNED 6/8/58 ACTUAL SIGNATURE J. Platt M.D. PHYSICIAN'S NAME (Type) J. PLATT, M.D. Esq md | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6-11-58 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR JUN 10 '58 | | 24b. REGISTRAR'S SIGNATURE Alf. Beach | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6636

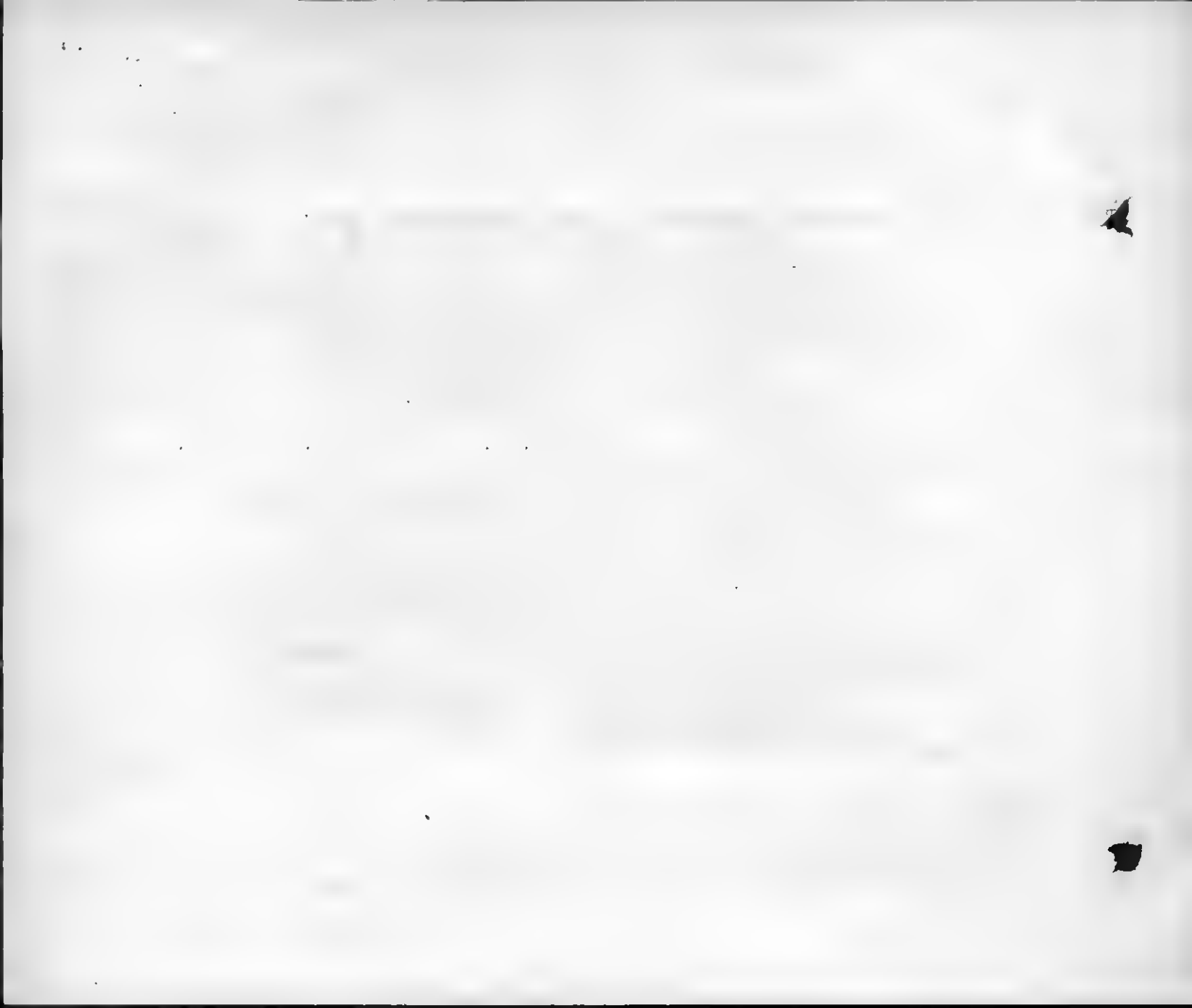
CERTIFICATE OF DEATH

Reg. Dist. No. 06629

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY IN 1b X Baltimore | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last WILHELM | | | | 4. DATE OF DEATH Month June Day 9 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 19, 1880 | 9. AGE (In years last birthday) 78 yrs. | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | | IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate | | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland | | 11. BIRTHPLACE (State or foreign country) USA | | |
| 13. FATHER'S NAME J Frank Wilhelm | | | | 14. MOTHER'S MAIDEN NAME Kate W. Gross | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. Wm. E. Koons - 10 W. Biddle St. | | 17. INFORMANT Address Wm. E. Koons - 10 W. Biddle St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE C.V. DISEASE - DUE TO 10 YEARS (c) SEVERE - C (CARDIAC ENLARG - | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from MAY 1, 1955 to JUNE 9, 1958 that I last saw the deceased alive on JUNE 9, 1958 and that death occurred at 7:30 P.M. from the causes and on the date stated above | | | | | | | |
| ACTUAL SIGNATURE Thomas E. Wheeler | | M.D. 3601 Chymal Rd | | ADDRESS (Street, city or town, state) | | DATE SIGNED 6/10/58 | |
| PHYSICIAN'S NAME (Type) THOMAS E. WHEELER | | Balto 5 - Md | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/12/58 | | 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost | | | | ADDRESS 4600 Liberty Heights Ave. | | 24a. REC'D BY REGISTRAR JUN 13 58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE W. E. Koons | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6637

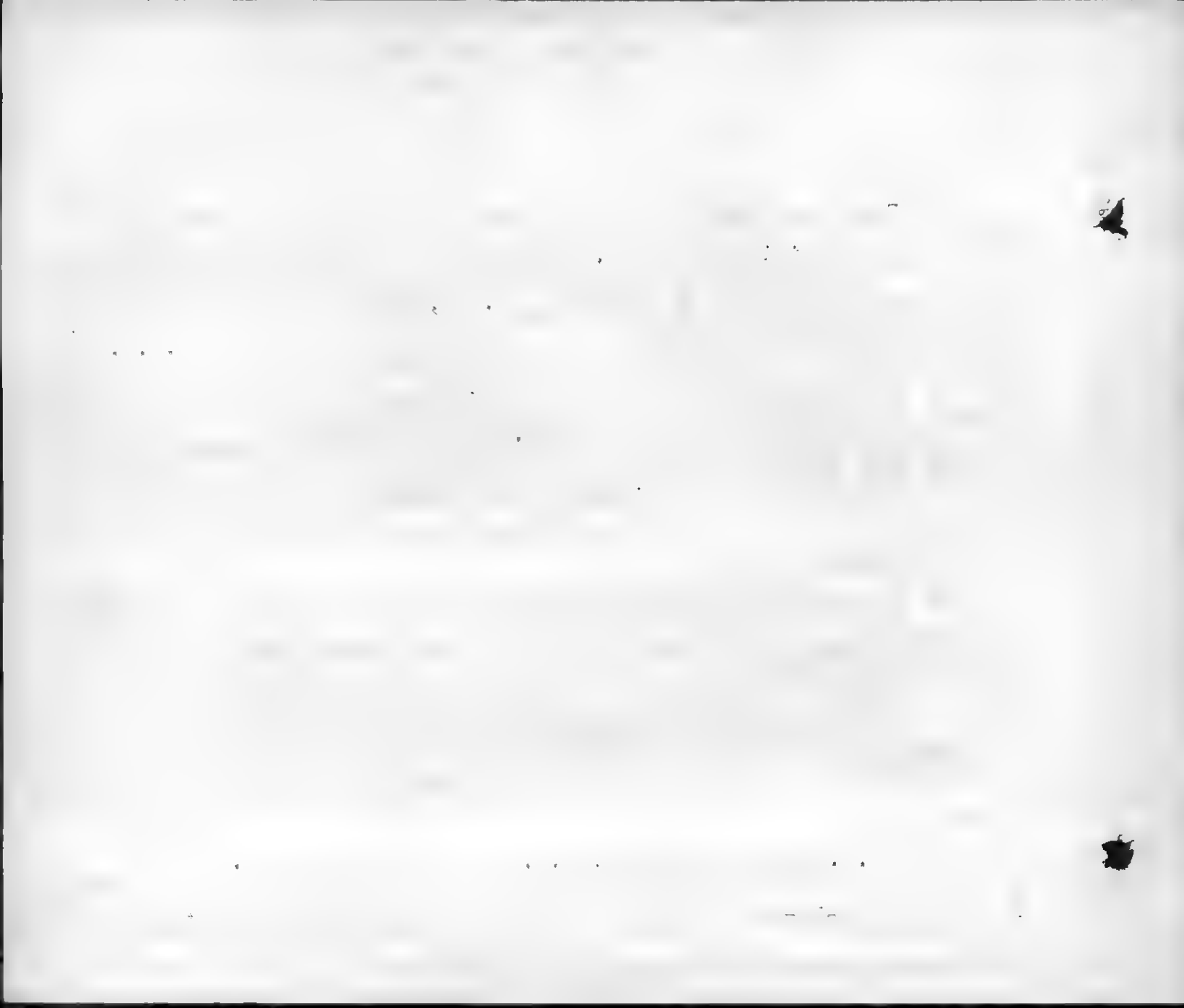
CERTIFICATE OF DEATH

Reg. Dist. No.

06630

| | | | | | | | |
|---|------------------------------------|--|---|--|--|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 Winters Lane | | | | d. STREET ADDRESS 304 Winters Lane | | | |
| 3. NAME OF DECEASED (Type or print) First Nettie Middle B. Last Williams | | | | 4. DATE OF DEATH Month June Day 6 Year 19 58 | | | |
| 5 SEX Female | 6. COLOR OR RACE Colored | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Dec. 11, 1886 | | 9 AGE (In years last birthday) 71 yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Dorsey | | | | 14. MOTHER'S MAIDEN NAME Mary Clark | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Laura Williams | | Address 304 Winters Lane | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arterio-sclerotic Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days 95 days | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 3rd 1958 to June 6th 1958 , that I last saw the deceased alive on June 6th 1958 , and that death occurred at 6 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED 6/6/58 | | | | | | | |
| ACTUAL SIGNATURE C. F. Maloney, M.D. | | | | M.D. 57 Winters Lane 6/6/58 | | | |
| PHYSICIAN'S NAME (Type) G. F. Maloney, M.D. | | | | Catonsville, 28. Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-10-58 | | 22c. NAME OF CEMETERY OR CREMATORY West Liberty | | 22d. LOCATION (City, town, or county) (State) Howard Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Mrs. E. E. Stanley | | | | ADDRESS 5784 | | 24a. REC'D BY REGISTRAR 11 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Alb... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



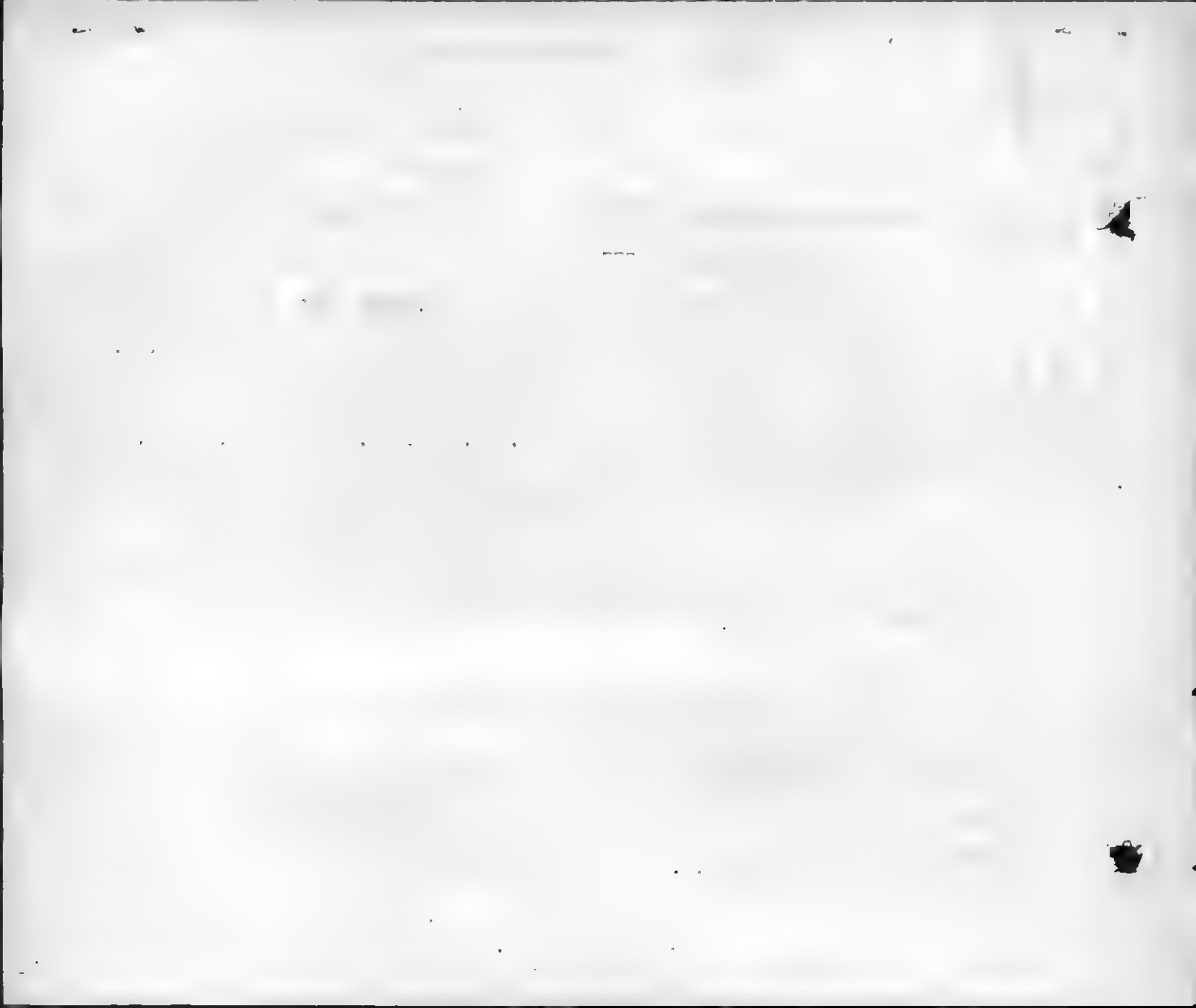
6638

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| c. LENGTH OF STAY IN 1b 12 Days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 2616 Beryle Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LORENZO Middle --- Last WILSON | | 4. DATE OF DEATH Month June Day 5 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 9, 1900 |
| 9. AGE (In years last birthday) 57 yrs | | IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY City | |
| 11. BIRTHPLACE (State or foreign country) Bible County, Alabama | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Lorenzo Wilson | | 14. MOTHER'S MAIDEN NAME Harriett MN: Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | 16. SOCIAL SECURITY NO. --- | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) --- | | INTERVAL BETWEEN ONSET AND DEATH 9 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CIRRHOSIS OF THE LIVER. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 7 A p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 24 , 19 58 , to June 5 , 19 58 , and that death occurred at 10:00 AM , from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE Irving Freeman | | ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND | |
| PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service | | DATE SIGNED 6/6/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-9-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | 24a. REC'D BY REGISTRAR Charles R. Law | |
| ADDRESS 802-04 Madison Ave. Baltimore 1, Md. | | 24b. REGISTRAR'S SIGNATURE Charles R. Law | |
| DATE JUN 10 '58 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6639 Items 1-5-58 et CERTIFICATE OF DEATH

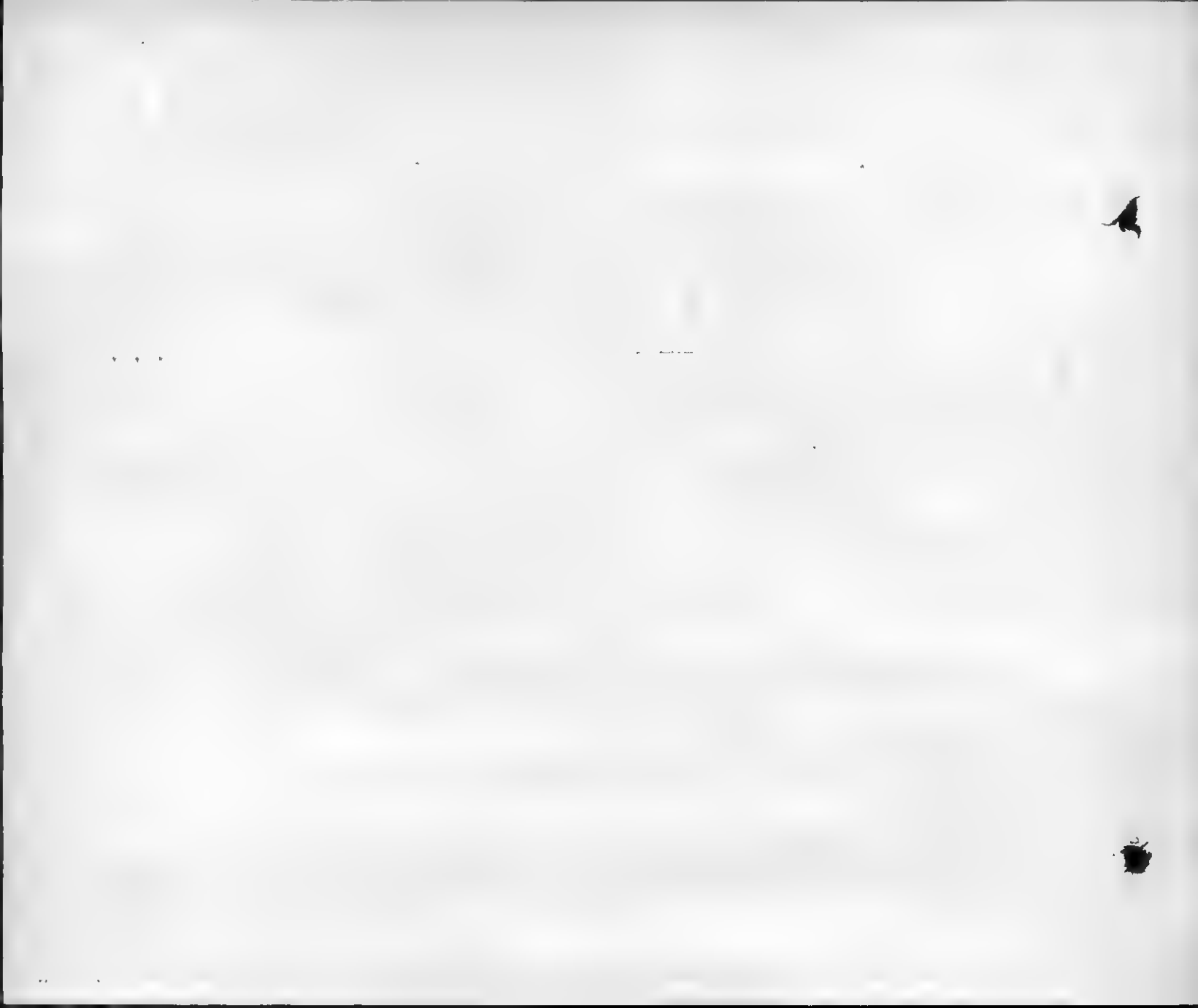
06632

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland | | | | c. LENGTH OF STAY IN 1b 9 mo. | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jennings, Maryland | | | | d. STREET ADDRESS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Michel Middle Loman Last Wilt | | | 4. DATE OF DEATH Month June Day 2 Year 19 58 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/7/57 (Correct) | | 9. AGE (In years last birthday) yrs. 11 | IF UNDER 1 YEAR Months 11 Days 25 | IF UNDER 24 HRS. Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Loman Wilt (See birth Cert.) | | | | 14. MOTHER'S MAIDEN NAME Rita Bittner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Rosewood Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus and DUE TO meningococci (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (blank) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH ONE month one month Birth | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1 19 58 to June 2 19 58 , that I last saw the deceased alive on June 2 19 58 , and that death occurred at 7:12 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Owings Mills, Md 31 DATE SIGNED June 5 | | | | | | | |
| ACTUAL SIGNATURE Harry G. Butler M.D. Owings Mills, Md | | | | | | | |
| PHYSICIAN'S NAME (Type) HARRY G BUTLER OWINGS MILLS MD | | | | | | | |
| 22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 6/4/58 | | 22c. NAME OF CEMETERY OR CREMATORY BITTINGER | | 22d. LOCATION (City, town, or county) (State) BITTINGER GARRETT Co Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Cor Newman, Gaithersburg, Md | | | | 24a. REC'D BY REGISTRAR DATE JUN 5 '58 | | 24b. REGISTRAR'S SIGNATURE Overhach | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6640

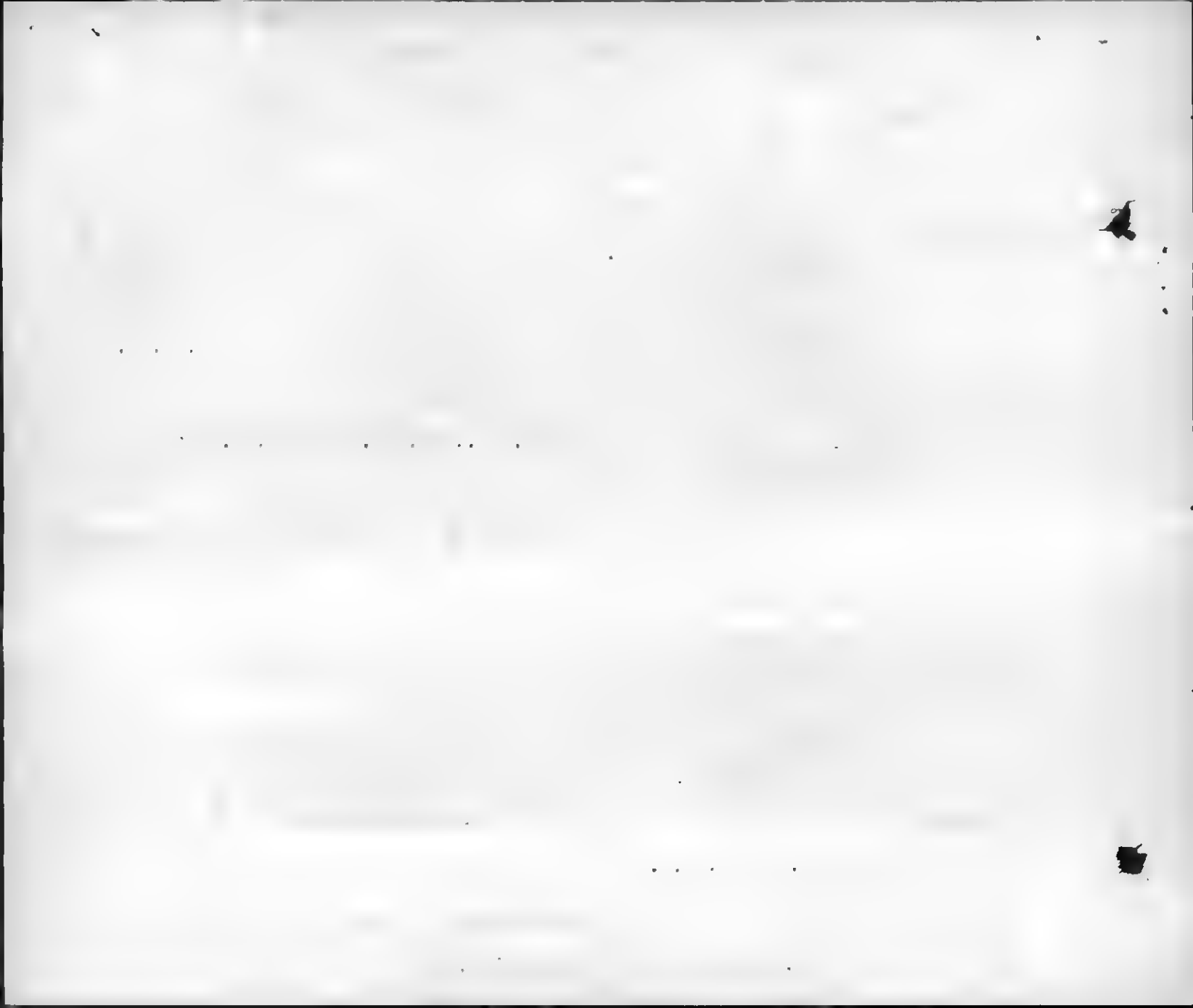
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm ssion) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 134 Days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. STREET ADDRESS 20 South Carrollton Avenue | |
| 3. NAME OF DECEASED (Type or print) First THOMAS Middle L. Last WIMPLING | | 4. DATE OF DEATH Month June Day 17 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 7, 1893 |
| 9. AGE (In years last birthday) yrs 64 | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician-unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | |
| 13. FATHER'S NAME Andrew Wimpling | | 14. MOTHER'S MAIDEN NAME Kate Faye | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | |
| 17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION 270.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LYMPHOSARCOMA, GENERALIZED DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 DAY 15 MONTHS | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 3, 1958, to June 17, 1958 and that death occurred at 9:55P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Charles T. Fitch | | ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND | |
| PHYSICIAN'S NAME (Type) CHARLES T. FITCH, M.D. | | DATE SIGNED 6/18/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6/21/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Cowan and Sons, Hollins and Poppleton, Balto. | | 24a. REC'D BY REGISTRAR JUN 19 '58 | |
| 24b. REGISTRAR'S SIGNATURE W. H. Beach | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6641

CERTIFICATE OF DEATH

Reg. Dist. No.

06634

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Balti ore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson | | c. LENGTH OF STAY IN 1b < Rural Towson | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road | | d. STREET ADDRESS Glenarm Road | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Alphonsina Winkler | | 4. DATE OF DEATH Month Day Year June 6 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 8, 1862 |
| 9. AGE (In years last birthday) 96 yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Francis Joseph | | 14. MOTHER'S MAIDEN NAME Mary Ann Gauges | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Sister M. Peter Fourier | | Address Notch Cliff, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio vascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from April 19 52 to June 19 58 that I last saw the deceased alive on April 22 19 58 and that death occurred at 8:35 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> | | ADDRESS (Street, city or town, state) 7501 York Road Towson, 4, Md. | |
| PHYSICIAN'S NAME (Type) Charles F. O'Donnell | | DATE SIGNED 6/6/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 6-9-58 | 22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM. | 22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles A. Geiler</i> | | ADDRESS 901 S. CONKLING ST. BALTO, 24, MD. | 24a. REC'D BY REGISTRAR 6/9/58 |
| | | 24b. REGISTRAR'S SIGNATURE <i>Deborah</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06635

6476

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7407 Waymouth Way</u> | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u> d. STREET ADDRESS <u>7407 Waymouth Way</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Winks</u> | | 4. DATE OF DEATH <u>June 1, 1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 8, 1907</u> |
| 9. AGE (In years last birthday) yrs. <u>50</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor Driver</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Knoxville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Thomas Winks</u> | | 14. MOTHER'S MAIDEN NAME <u>Mollie Corder</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.II</u> | | 16. SOCIAL SECURITY NO. <u>218-01-8842</u> | |
| 17. INFORMANT <u>Mr. Ryder, 7407 Waymouth Way, DUNDALK 22</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CH of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) <u>5-26 1958</u> | |
| 21. I certify that I attended the deceased from <u>5-26 1958</u> that I last saw the deceased alive on <u>6-1 1958</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>21 Kinship Rd BAL 22</u> DATE SIGNED <u>6-2-58</u> | | | |
| ACTUAL SIGNATURE <u>Sack & Collins</u> | | PHYSICIAN'S NAME (Type) <u>Sack & Collins</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6-5-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> | | 24a. REC'D BY REGISTRAR <u>JUN 4 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Deborah</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

06636

Reg. Dist. No.

6642

| | | | |
|--|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE FLORIDA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOOD LAWN. | | c. LENGTH OF STAY IN 1b 26 Yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HUGSBURG HOME. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEL REY BEACH FLA | |
| 3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE WOLF | | 4. DATE OF DEATH Month Day Year 6/11/1958 | |
| 5. SEX F | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV. 22 1861 |
| 9. AGE (In years last birthday) yrs. 96 | | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) BALTO. MD |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME CHRISTIAN WOLF | |
| 14. MOTHER'S MAIDEN NAME DOROTHY ? | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. — | | 17. INFORMANT RECORDS AUG. HOME Address 6811 CAMPFIELD RD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arterio-sclerosis. DUE TO (c) — | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 20g. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/24/1947 to 6/11/1958 , that I last saw the deceased alive on June 11, 1958 , and that death occurred at 8 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Earl L. Chambers M.D. 4108 Liberty St. Balto. - 7 - Md. 6-13-58 | | DATE SIGNED 6-13-58 | |
| PHYSICIAN'S NAME (Type) Earl L. Chambers - | | ADDRESS 4108 Liberty Sts Balto. - 7 - Md. | |
| 22a. BURIAL CREMATION REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 6/14/58 | 22c. NAME OF CEMETERY OR CREMATORY IMMANUEL | 22d. LOCATION (City, town, or county) (State) BALTO MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE PAUL F. MEEMANN | | ADDRESS 6067 HARE RD. | |
| 24a. REC'D BY REGISTRAR JUN 16 '58 | | 24b. REGISTRAR'S SIGNATURE W. H. H. H. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6643

CERTIFICATE OF DEATH

06637

Reg. Dist. No.

| | | | |
|---|---------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY BALT. CITY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN TB 5 years 3 m. 22 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE ST. HOSP. | | d. STREET ADDRESS 1624 ME. Royal Ave. | |
| 3. NAME OF DECEASED (Type or print) First MARY Middle GRACE Last WRIGHT | | 4. DATE OF DEATH Month 6 Day 28 Year 1958 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-24-1885 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) 73 yrs |
| 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME JOHN F. ZIMMERMAN | | 14. MOTHER'S MAIDEN NAME KATHERINE BROGAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Y (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. ELISABETH KEECH | | Address 183 Sanford St. Great Falls N.Y. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal obstruction 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant lymphoma of neck DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease (old) | | | INTERVAL BETWEEN ONSET AND DEATH 4 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 7/1 , 19 53 , to 6/28 , 19 58 , that I last saw the deceased alive on 6-28-1958 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Bruno Radauskas | | ADDRESS (Street, city or town, state) Spring Grove St. Hospital Catonsville 28, Md. | |
| PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS | | DATE SIGNED 6/29/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF July 1/58 | 22c. NAME OF CEMETERY OR CREMATORY Louisa Park | 22d. LOCATION (City, town, or county) (State) Baltimore 29 Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave | | 24a. REC'D BY REGISTRAR DATE JUL 1 '58 | |
| 24b. REGISTRAR'S SIGNATURE Witzke | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10. The following information is available for the year ended 31/12/2014:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6644

CERTIFICATE OF DEATH

06638

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--|---|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-WOODLAWN</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-WOODLAWN</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1919 FEATHER BED LANE</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | First Middle Last | | 4. DATE OF DEATH | | Month Day Year | |
| | | <u>HENRY ADOLPH ZEIGLER</u> | | <u>6</u> <u>2</u> <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 9, 1871</u> | 9. AGE (In years last birthday) <u>87</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>GEORGE F. ZEIGLER</u> | | | | 14. MOTHER'S MAIDEN NAME <u>WEIDEMEYER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT (SON) <u>HENRY ZEIGLER</u> | | Address <u>1919 FEATHER BED LANE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>CONGESTIVE HEART FAILURE</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>2 YEARS</u> <u>6 MONTHS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>JAN 16, 1954</u> to <u>JUNE 2, 1958</u> , that I last saw the deceased alive on <u>MAY 31, 1958</u> , and that death occurred at <u>1:50 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD BALTO. MD.</u> | | DATE SIGNED <u>6/2/58</u> | |
| PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u> | | | | <u>BALTO. MD.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>6/5/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u> | | 22d. LOCATION (City, town, or county) (State) <u>RANDAUSTRON MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.T. STANSBURY</u> ADDRESS <u>WOODLAWN MD.</u> | | | | 24a. REC'D BY REGISTRAR <u>JUN 4 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. L. ...</u> | |

